Central Intelligence Agency

Washington, D.C. 20505

OCA FILE Dept Kennedy
OHC, leg

23 June 1988
OCA 88-2123

The Honorable Augustus F. Hawkins
Chairman
Committee on Education and Labor
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Director has asked me to respond to your letter dated 10 May 1988, which we received on 8 June, requesting information regarding implementation by the Central Intelligence Agency of the Civil Rights Restoration Act of 1987.

As you know, the House Permanent Select Committee on Intelligence and the Senate Select Committee on Intelligence have responsibility for oversight of the Agency's activities. Since the material that you have requested could involve information pertaining to intelligence sources and methods, we believe that our oversight committees are in the best position to monitor in an effective and secure fashion the Agency's implementation of this legislation. We are providing a copy of your letter to Chairman Stokes and will make clear our willingness to cooperate with the House Intelligence Committee on this matter.

A similar letter is being sent to Chairman Kennedy.

Sincerely,

STAT

Director of Congressional Affairs

OCA 2123-88

SUBJECT: Letter to Chairman Hawkins in response to letter regarding the Civil Rights Restoration Act.

OCA/LEG/ [redacted] (22 June 1988) STAT

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U.S. House of Representatives
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS
511 HOUSE OFFICE BUILDING ANNEX 1
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STAT

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OVERSIGHT HEARINGS ON THE FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM

WEDNESDAY, MAY 11, 1988

STAT

WITNESS LIST

HONORABLE PAT SCHROEDER

HONORABLE CONSTANCE HORNER, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

MR. JOHN A. NELSON, PRESIDENT, COMMUNITY HEALTH CARE PLAN, SPEAKING FOR THE GROUP HEALTH ASSOCIATION OF AMERICA

DR. JOHN MCGRATH, SPEAKING FOR THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION

DR. BRYANT L. WELCH, EXECUTIVE DIRECTOR FOR PROFESSIONAL PRACTICE, AMERICAN PSYCHOLOGICAL ASSOCIATION

DR. LARRY KLINE, CO-CHAIRMAN, COALITION FOR ADEQUATE MENTAL HEALTH, ALCOHOLISM AND DRUG ABUSE SERVICES

See last handout – HealthCare COMPARE was invited to submit written testimony. Exhibit A is an excellent succinct description of how their programs work.

GARY L. ACKERMAN, NEW YORK, CHAIRMAN
MARY ROSE OAKAR, OHIO
MICKEY LELAND, TEXAS
JOHN T. MYERS, INDIANA
CONSTANCE A. MORELLA, MARYLAND

U.S. House of Representatives
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Opening Statement
Gary L. Ackerman, Chairman
May 11, 1988

Today, the Subcommittee on Compensation and Employee Benefits will conduct the first of two oversight hearings on the Federal Employees' Health Benefits Program.

The FEHBP is an $8.8 billion health insurance program, providing insurance coverage to approximately 11 million Federal workers, retirees and their dependents.

All Americans are adversely affected by the constantly increasing costs of medical care. Health care costs are rising almost twice as fast as the general inflation rate. Therefore, it is critical that FEHBP enrollees have adequate and affordable health insurance. Yet Federal employees are particularly disadvantaged since they pay approximately 40 percent of their health insurance premiums, while the majority of private employees pay nothing.

On the average, FEHBP premiums have increased by approximately 31 percent this year -- some plans' rates rose in excess of 70 percent -- and the premium inflation is unlikely to abate in the 1989 contract year. In part, these premium increases reflect the failure of recent efforts to control FEHBP health care costs. Health economists attribute the cost increases to the following factors: The volume of outpatient services is rising by staggering proportions; new medical technologies are extremely expensive and are being used more frequently; the population is aging, with accompanying costs for the treatment for chronic diseases; hospitals are significantly increasing the charges for treatments not covered by cost-control efforts; and many FEHBP plans are being plagued by adverse selection.

As one strategy in combating health care inflation, I strongly believe that FEHBP carriers and OPM need to pay more attention to cost-containment through health promotion programs. The preponderance of data indicates that these programs, which

STATEMENT OF REP. PAT SCHROEDER
ON FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM
BEFORE SUBCOMMITTEE ON
COMPENSATION AND EMPLOYEE BENEFITS
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
May 11, 1988

Thank you for inviting me to participate in today's oversight hearing on the Federal Employees Health Benefits Program (FEHBP). The study recent released by the Office of Personnel Management confirmed what most of us already knew - the health program for federal employees is sick. It is not working for the federal government as an employer; it is not working for federal employees; and, it is not working for the taxpayers.

The program needs radical surgery. We must not be seduced by promises of a quick fix. An easy but misguided approach would be to cut existing benefits and limit new ones. FEHBP, the largest employer-provided health program in America, ought to be able to provide top-of-the-line coverage at reasonable cost. Yet, as the OPM report demonstrated, FEHBP does not use competition to win better coverage at lower cost.

The problems with FEHBP stem from the fact that we cannot decide which master the health program is supposed to serve. It serves as primary medical insurance for a huge group of retirees, who have greater medical needs than active duty workers on average. It serves as a membership tool and fundraising device for employee organizations. And the Administration and some in Congress have made it serve as an instrument of social morality by banning abortion coverage.

Let me propose a radical concept: the Federal Employee Health Benefit Program should serve federal employees. It should provide them with the best possible coverage at the lowest cost. It should, like pay and retirement, serve as a tool to recruit and retain top quality federal workers. To be effective, it must keep current with advances in health care and medical technology.

In your redesign of the system, I urge you to keep this goal in mind. You will have to deal with the other masters of the program. But, you should strive to design a program which places service to federal workers first and foremost.

Health coverage for federal employees is falling behind what is available in the private sector. The inefficient design of FEHBP means that the costs are too high and skimping on benefits is used to control costs. We should make the program more efficient so that it can provide comprehensive coverage.

Let me give you a few areas in which FEHBP is falling behind. One is the coverage of infertility. Infertility is a medical condition caused by any one of a large number of disease conditions. It is a devastating problem which undermines marriages, careers, and self-image. Nearly five million couples, almost one out of every five, has trouble conceiving a baby. In the 20 to 24 year old age group, the incidence of infertility is rapidly growing.

Most FEHBP plans will cover diagnosis of fertility problems but fail to cover treatment. This precludes many federal employees from having a family. In the last few years, medical science has made tremendous strides in the treatment of infertility. The great majority of infertility problems can be handled with conventional treatment. For others, microsurgical techniques and drug therapy are the only hope.

Offering coverage for innovative but medically proven treatments such as artificial insemination (AI), in vitro fertilization (IVF) and gamete intrafallopian transfer (GIFT) is a growing trend. The Health Insurance Association of America found that companies covering IVF account for 41% of the industry. Many companies found that coverage of the procedure was the most cost-effective way to remedy the condition. Five states have passed laws requiring health insurers to cover or offer procreative services, including IVF, as part of their policies. Other states are considering similar legislation. The Iowa Supreme Court has defined infertility as an illness and required health insurers to cover fertility treatments including artificial insemination and IVF.

IVF and GIFT are treatments of last resort and relatively few infertile couples will pursue them. The significant physical and emotional tolls associated with treatment will deter many. But these treatments -- and the insurance to cover them -- should be available to those who choose it and know it to be their only chance for a family.

Because many federal employees are now choosing adoption as a means of family building, FEHBP rules should be revised to allow for coverage under the health benefits of the adoptive parent of the birth expenses of a child to be adopted. Adoption costs are exceedingly high and the federal government provides its employees no assistance. According to a 1985 study by the National Adoption Exchange, nine companies offer adoption benefits in some form of insurance.

I have heard the argument against adoption coverage many times: adoption expenses are not medical and should not be covered by health insurance. Until a few years ago, the carriers said the same thing about pregnancy. They said it was neither an illness nor an injury and, therefore, should not be covered. The point is we determine what are appropriate situations to cover under health insurance. Adoption is an alternative to pregnancy and childbirth. If pregnancy and childbirth are covered by health insurance, so should adoption.

Coverage of medical costs involved with adoption and treatment for infertility should not be viewed as increasing or expanding health

insurance benefits but rather as means of providing a basic level of benefits consistent with society's traditional family expectations.

Another area in which FEHBP is falling behind is in establishing a health care continuation provision for federal employees, similar to what was provided by title X of the Consolidated Omnibus Budget Reconciliation Act of 1985. This law requires private employers to provide employees and their families the option of continued coverage under the group health insurance plan. In cases of termination of employment or change of family status, employees and their family members may continue coverage at their own expense. Right now, once employees leave federal service their only option is to convert to a far more expensive individual policy. They may no longer participate in the less costly group plan.

FEHBP must be receptive to consumer health care demands as well as innovative and medically proven treatments. And, the federal employee health program can keep pace with the private sector through a better designed system. I will be delighted to work with you to design such a system.

STATEMENT OF
HONORABLE CONSTANCE HORNER
DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

BEFORE THE

SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
UNITED STATES HOUSE OF REPRESENTATIVES

ON

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

MAY 11, 1988

GOOD AFTERNOON, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR INVITING ME HERE TODAY TO DISCUSS THE STATUS OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP). I AM ACCOMPANIED THIS MORNING BY JEAN BARBER, OUR ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE.

OVER THE PAST SEVERAL YEARS, WE HAVE GROWN INCREASINGLY CONCERNED ABOUT A NUMBER OF PROBLEMS IN THIS 28-YEAR OLD PROGRAM. WE HAVE SEEN, FOR EXAMPLE, TREMENDOUS VOLATILITY IN THE PREMIUMS, MASS MOVEMENT OF ENROLLEES DURING OPEN SEASON, AND GROWING INEQUITIES IN THE TREATMENT OF VARIOUSLY SITUATED GROUPS AND INDIVIDUALS.

SIX MONTHS AGO, I COMMISSIONED A COMPREHENSIVE EVALUATION OF THE FEHBP TO ASSESS THE CAUSES OF THESE AND OTHER PROBLEMS AND TO MAKE RECOMMENDATIONS FOR PROGRAM IMPROVEMENTS. THE STUDY

WAS UNDERTAKEN BY THE CONSULTING FIRM OF TOWERS, PERRIN, FORSTER & CROSBY, WHO WORKED CLOSELY WITH OPM PROFESSIONAL STAFF AND WHO WERE GRANTED FULL ACCESS TO THE AGENCY'S HISTORICAL RECORDS, FILES, AND DATA COLLECTIONS.

LAST WEEK I MADE THE RESULTS OF THE STUDY PUBLIC. THE CONSULTANT'S REPORT CONCLUDES THAT THE PROGRAM IS TREMENDOUSLY INEFFICIENT, COSTING THE GOVERNMENT AND ENROLLEES IN EXCESS OF ONE-HALF BILLION DOLLARS A YEAR MORE THAN NECESSARY. EVEN MORE SIGNIFICANTLY, THE REPORT CONCLUDES THAT DESPITE THESE EXCESSIVE EXPENDITURES, THE HEALTH CARE NEEDS OF MANY OF OUR ENROLLEES ARE BEING SERVED POORLY. IN THE OPINION OF OUR CONSULTANT, THE PROBLEMS IN THE FEHBP ARE NOT SELF-CORRECTING, AND THE PROGRAM WILL CONTINUE TO DETERIORATE UNLESS MAJOR LEGISLATIVE REFORM IS UNDERTAKEN.

WE BELIEVE THE DIAGNOSIS OF THE PROBLEMS OF THE FEHBP IN THE CONSULTANT'S REPORT IS SUBSTANTIALLY CORRECT. WE ARE ALSO PLEASED THAT THE CONSULTANT HAS PROVIDED A BROAD RANGE OF ALTERNATIVE PROGRAM DESIGNS THAT WOULD ADDRESS THESE PROBLEMS FOR US AND OTHERS INTERESTED IN THE PROGRAM TO CONSIDER. GIVEN THE COMPLEXITY OF THE ISSUES AND THE MANY DIVERGENT NEEDS AND INTERESTS THAT NECESSARILY COME INTO PLAY, WE ARE UNDER NO ILLUSION THAT FEHBP REFORM WILL BE QUICK OR EASY. NONETHELESS, THE URGENCY OF THE SITUATION AS DESCRIBED IN THE CONSULTANT'S REPORT DEMANDS THAT WE BEGIN AT ONCE.

I PLAN TO USE THE REPORT IN THE COMING WEEKS AS A WORKING PAPER -- A BASIS FOR DISCUSSION WITH A BROAD SPECTRUM OF GROUPS AND INDIVIDUALS. IN ADDITION TO SOLICITING THE VIEWS OF THOSE INSURERS AND EMPLOYEE ORGANIZATIONS CURRENTLY PARTICIPATING IN THE PROGRAM, OPM PLANS TO REACH OUT TO THE LARGER INSURANCE AND EMPLOYEE BENEFITS INDUSTRY, TO VARIOUS RESEARCH AND PUBLIC POLICY GROUPS, AND TO THE ACADEMIC COMMUNITY. WE WILL ALSO BE HOLDING DISCUSSIONS WITH THE FEDERAL AGENCIES. LAST, BUT CERTAINLY NOT LEAST, WE WILL BE SEEKING WAYS TO ASCERTAIN THE VIEWS OF FEDERAL EMPLOYEES AND RETIREES. FROM THE CORRESPONDENCE WE RECEIVE, WE SENSE GREAT DISSATISFACTION WITH THE PROGRAM ON THE PART OF THOSE IT IS SUPPOSED TO BENEFIT AND WE BELIEVE FAR TOO LITTLE ATTENTION HAS BEEN PAID IN THE PAST TO WHAT OUR ENROLLEES REALLY WANT AND NEED IN A HEALTH INSURANCE PROGRAM.

WE WILL ALSO, OF COURSE, BE STUDYING THE POSSIBLE ADMINISTRATIVE ACTIONS OUTLINED IN THE REPORT. WHILE WE CONCUR IN THE CONSULTANT'S OPINION THAT ADMINISTRATIVE ACTION ALONE CANNOT SOLVE THE FEHBP'S PROBLEMS, WE WILL NONETHELESS WEIGH WHAT AMELIORATIVE STEPS COULD BE POSSIBLE.

WITH REGARD TO THE NEAR-TERM FUTURE OF THE PROGRAM, RATE AND BENEFIT NEGOTIATIONS FOR THE 1989 CONTRACT YEAR WILL BEGIN IN THREE WEEKS. FROM THE INFORMATION CURRENTLY AVAILABLE TO US, WE SEE NO EVIDENCE OF ABATEMENT IN MEDICAL INFLATION, AND, HENCE, WE MUST ANTICIPATE ANOTHER YEAR OF SIGNIFICANT RATE

INCREASES IN MANY OF OUR PLANS. THE SITUATION WILL BE MORE SEVERE FOR SOME OF OUR CARRIERS BECAUSE OF THE RESULTS OF LAST YEAR'S OPEN SEASON. WE EXPERIENCED A FURTHER EXODUS OF RELATIVELY HEALTHY ENROLLEES FROM THE TWO HIGH OPTIONS OF THE GOVERNMENT-WIDE PLANS, THUS EXACERBATING THE PHENOMENON DESCRIBED IN THE REPORT OF THE ISOLATION OF SICK AND ELDERLY ENROLLEES IN THESE PLANS. WE HAVE GRAVE DOUBTS THAT UNDER THE CURRENT PROGRAM STRUCTURE THE DOWNWARD SPIRAL IN WHICH THESE TWO PLANS FIND THEMSELVES CAN BE HALTED OR REVERSED.

SEVERAL YEARS AGO, WHEN HEALTH CARE INFLATION TEMPORARILY ABATED, I BELIEVE WE WERE ALL LULLED INTO A MISTAKEN SENSE THAT THE FEHBP'S PROBLEMS WERE NOT SERIOUS. WE KNOW BETTER NOW. THERE LIKELY WILL NOT BE SUFFICIENT TIME LEFT IN THIS ADMINISTRATION TO FASHION A SOLUTION THAT IS ACCEPTABLE TO A MAJORITY OF THE PARTIES CONCERNED. AT A MINIMUM, HOWEVER, I INTEND TO LEAVE MY SUCCESSOR WITH THE NECESSARY FOUNDATION OF FACT, INFORMED OPINION, AND EXPERT ADVICE ON WHICH A BETTER PROGRAM CAN BE ERECTED.

I WOULD BE HAPPY TO ANSWER YOUR QUESTIONS.

STATEMENT OF
JOHN A. NELSON
PRESIDENT

COMMUNITY HEALTH CARE PLAN

ON BEHALF OF THE
GROUP HEALTH ASSOCIATION OF AMERICA

BEFORE THE
SUBCOMMITTEE ON COMPENSATION
AND EMPLOYEE BENEFITS

COMMITTEE ON POST OFFICE AND CIVIL SERVICE
U.S. HOUSE OF REPRESENTATIVES

ON

THE FEDERAL EMPLOYEES
HEALTH BENEFITS PROGRAM

MAY 11, 1988
WASHINGTON, D.C.

Good afternoon Mr. Chairman and members of the Subcommittee, my name is John Nelson and I am Executive Director of Community Health Care Plan (CHCP), a 72,000 member health maintenance organization (HMO), based in New Haven, Connecticut. I am here today on behalf of the Group Health Association of America (GHAA). GHAA is the national trade association for managed care, representing approximately 70 percent of the nearly 30 million HMO enrollees across the country. I am accompanied today by Erling Hansen, GHAA General Counsel and Leslie Rose, Deputy Legislative Director.

Today, I would like to discuss the participation of HMOs, also known as comprehensive medical plans (CMPs), in the Federal Employees Health Benefits Program (FEHBP). We will submit later for the record a much longer and more detailed statement which will respond to the Office of Personnel Management (OPM)

study recently released and include our recommendations for changes in the FEHBP.

For HMOs, the FEHBP respesents an important segment of the marketplace. In fact, for many HMOs, federal workers represent the single largest source of enrollment. This is certainly true for my plan-we have 6,604 federal enrollees.

In exchange for a fixed premium, HMOs provide a comprehensive range of health care benefits with an emphasis on preventive care and treatment in an ambulatory setting. HMOs are able to provide cost efficient and high quality care because their delivery structure allows them to control utilization, particularly in the area of inpatient care. HMOs reported average inpatient utilization of 427 inpatient days per 1,000 versus a national average of 920 days per 1,000 last year (excluding Medicare) according to the American Hospital Association.

In FEHBP, HMOs cover nearly 2 million people or 20 percent of federal workers, annuitants and their dependents. In 1970, there were only 10 HMOs in the FEHBP serving less than 4 percent of federal workers.

For the 1988 contract year, 406 HMOs contract with OPM to provide health care to federal employees, annuitants and their dependents. Although 406 HMOs participate in the program, the reality is that only a few are actually available in different geographic areas. For example, areas with the most HMOs in the FEHBP, such as Chicago and Los Angeles, actually provide no more than 10 HMO options because of their health service delivery area. In most areas the number of HMOs available is smaller.

Part of the success for the increase in FEHBP enrollment in HMOs over the past few years is related not only to the comprehensiveness of benefits, but also to the reasonableness of HMO premiums. During the last few years, HMO premiums have increased more slowly than the fee for service sector, both in general and in the FEHBP. For the 1988 benefit year, HMO premiums increased an average of 5-10 percent contrasted with the average premium increase of 32 percent by the fee for service carriers. As you are well aware Mr. Chairman, some premiums were even more sharply increased.

Due to the way the government contribution is determined by the so-called "Big Six" formula the government contribution was substantially increased this year. This in combination with the small increase in HMO premiums, means some federal workers will pay no more for their HMO health coverage this year than they did last year and some may even pay less. This is one very tangible reason why we expect the last open season, when all the results are in, to be one of the most successful ever.

We feel strongly that HMO participation in the FEHBP has been largely positive, providing an alternative health care option for federal workers which is priced well and yet has helped keep government costs down. For example, if Kaiser North and Kaiser South, who recently increased their premiums approximately 7 percent were not part of the "Big Six" the government contribution would be even higher this year.

We do recognize, however, that there are some problems with the program. Most of these are not new problems and have been discussed for the past 10 years. When OPM contracted for a study of the entire

program and when Congress requested a study on the viability of a separate Medicare supplemental option under FEHBP we looked forward to the report.

We were disappointed in the final product. The report covers a broad area and includes useful historical and background information. It also highlights the issues and makes several useful recommendations such as elimination of the "Big Six" formula to set the government contribution and the creation of a separate Medicare supplemental option. However, we are very concerned about the treatment of HMOs in the report.

Frankly, Mr. Chairman we feel the report is very critical of HMOs, and seems to blame HMOs for some of the inflationary aspects of the program. Many of its conclusions have no basis in fact or rational explanation. There are omissions in the report-in the entire section on cost containment the word "HMO" does not even appear, yet we pioneered many of the cost containment techniques OPM has been urging fee for service plans to use for years. Our analysis will also detail inaccuracies such as the discussion of plan reserves and financial solvency as it relates

to HMOs. We are particularly concerned about the report's unsubstantiated charge that HMOs deliberately and inadvertently attract healthier risks. This is an old and ongoing charge used against HMOs. HMOs may be adversely selected just as fee for service plans are. Maternity and well baby care, and a prescription drug program are two classic examples. In addition, OPM's suggestion that HMOs may locate in desirable areas to attract healthier people is simply not the case. HIP, a plan you know well Mr. Chairman, serves 1 million people in the New York area including those areas which may be considered medically underserved-these are not where the low health risks reside.

Due to the time limitations we cannot fully detail here all our problems with the OPM report or our recommendations for reform of the FEHBP. However, the most important point is that HMOs have been a positive force in FEHBP. We are confident, Mr. Chairman, that in your consideration of possible reforms to the program, you will consider HMOs to be part of the solution and not just a problem. We look forward to working with you. I'd be happy to answer any questions.

American Psychiatric Association

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

AND THE

AMERICAN MEDICAL ASSOCIATION

ON THE

FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

PRESENTED BY

JOHN MCGRATH, M.D.

BEFORE THE

SUBCOMMITTEE ON COMPENSATION & BENEFITS
HOUSE POST OFFICE AND CIVIL SERVICE COMMITTEE

MAY 11, 1988

Mr. Chairman, Members of the Subcommittee, I am John McGrath, M.D., a physician in the private practice of psychiatry in Washington, D.C., testifying as both the Chairman of the Joint Commission on Government Relations of the American Psychiatric Association, a national medical specialty society representing over 34,000 psychiatrists and a member of the American Medical Association's Council on Legislation. The AMA and the APA have a long standing relationship and have worked side by side on many fronts, including the ongoing battle to eliminate discrimination in the FEHBP. We appreciate the opportunity to present testimony on the future of the Federal Employees Health Benefits Program and ask that in addition to the statement submitted for today's record, the AMA be allowed to submit separate written comments after the hearing's conclusion.

Rising health care cost and a continuing tradition of discriminating against the mentally ill, have resulted in coverage for mental and addictive disorders that can only be described as dangerously inadequate. We wish to applaud the leadership you have taken and the deep concern expressed by the Members of the Subcommittee regarding the future of the FEHBP and its ability to provide responsible comprehensive coverage at affordable prices, especially if the illness is due to a mental or addictive disorder.

The story of the denigration of the FEHBP as a standard for good coverage of psychiatric care is one that this Subcommittee has heard often from us, other mental health care providers, and from those directly affected by the reduction, the workers, their dependents and annuitants. Unfortunately, the tale continues to require telling.

Fortunately, thanks to the work of Towers, Perrin, Forster & Crosby, the old story is now the subject of renewed attention. For years we have been stating what to us appears obvious; benefit reduction has deprived enrollees of essential coverage. Combine that with the FEHBP's inherent practice of adverse selection and the result is a health care system which no longer serves to protect the sick. The TPF&C report, in a contract let by the Office of Personnel Management for the purpose of evaluating the entire FEHBP, has essentially confirmed what we have always known. The report adds new credence to our argument that the system must be reformed by setting minimum benefit levels minimum thereby alleviating the "risk selection" factor and effectively reducing the cost of health care.

Despite historic evidence that the cost of covering mental and nervous illness was stable and predictable and had held at roughly 7.7 percent of all health benefits paid, mental health benefits have been greatly reduced to a point that is now much less than that provided in the private sector.

A study conducted by the General Accounting Office in December 1986, entitled, "Comparison of Coverage for Federal and Private Sector Employees," states:

> FEHBP plans have generally curtailed the mental health benefit since 1980, in areas such as the number of days of hospitalization covered, the total benefits paid, and the level of deductibles and coinsurance the enrollee must pay.

In 1980, most FEHBP plans (15 of the 18 largest) paid 100 percent of initial mental health expenses for a specified time or to a specified dollar limit. But in 1982, mental health coverage was substantially curtailed. Plans reduced their mental health benefits by (1) covering fewer days of hospitalization, (2) limiting the covered treatment costs, (3) limiting the number of outpatient treatments, (4) raising deductibles, or (5) lowering coinsurance rates. In 1984, OPM asked the plans to restructure the benefit to improve long-term inpatient coverage by adding catastrophic protection. In doing so, the plans further reduced coverage for outpatient care and short-term hospitalizations. Also, in 1984, 12 plans limited their lifetime inpatient mental health coverage to a specified maximum, typically ranging from $50,000 to $75,000. Before this change only four plans had lifetime maximums.

To illustrate the impact of these cuts on the FEHBP the General Accounting Office study, using five likely treatment scenarios, developed by the American Psychiatric Association, calculated the percentage of charges nine large FEHBP plans would pay for each scenario. The results were as follows.

"For short-term inpatient care of 10 days combined with 62 outpatient treatment visits, average coverage was 69 percent of charges in 1980, declining to 56 and 42 percent in 1982, and 1984, respectively.

For short-term outpatient treatment of 18 visits, average coverage was 66 percent of charges in 1980, declining to 46 and 40 percent in 1982 and 1984, respectively.

For two hospitalizations of 15 to 20 days each combined with 85 outpatient treatment visits, coverage declined from 74 percent of charges in 1980 to 63 and 52 percent in 1982 and 1984, respectively.

For long-term hospitalizations of 180 days combined with 75 outpatient treatment visits, coverage declined from 54 percent of charges in 1980 to 23 percent of charges in 1982 and then increased to 53 percent in 1984."

An APA conducted study of FEHBP indicated, in fact, that most of the plans cut benefits by more than 25 percent between 1980 and 1984, with many of the larger plans cutting benefits by 50 percent or more. By contrast, the cuts in the benefits for physical health care were only 6 or 7 percent of the total package. To further illustrate these inequities, in our study we compared the out-of-pocket costs for an employee incurring either $10,000 or $100,000 in inpatient physical health care expenses in a year to those incurred for inpatient mental health care, under 1985 coverage. In all plans, physical illness is fully protected once a limit (usually $2500) is reached. However, the enrollee incurring $10,000 in mental health costs has to spend $8,000 out-of-pocket, and if the expenses are $100,000, the out-of-pocket cost can be as high as $75,000. It is not difficult to imagine the plight of an employee or annuitant who is suddenly faced with this

type of expense; consider the following.

"I have had a problem with inadequate psychiatric coverage. Two years ago my adolescent daughter, away at college, made a serious suicide attempt. She needed a full year of hospitalization at a private psychiatric hospital. My coverage under NALC, however, provided for only eight months of coverage and that with a copayment of $7,000. This represented a catastrophic expense to me as a divorced mother earning on $13,000 a year at my government job; however, my "catastrophic" coverage didn't seem to extent to this expense. Fortunately, my former husband was able to secure coverage for the remainder of our daughter's hospitalization and for her outpatient treatment since. She is now doing well in her studies at a Baltimore college and is happily engaged in many extracurricular activities as well. However, I am distressed to realize that my NALC coverage will pay for lifesaving heart and liver transplants but no more than a $50,000 lifetime total for what can also be lifesaving treatment in a psychiatric hospital."

"My husband is currently a patient at Sheppard-Pratt Hospital in Baltimore. He has had 30 days care on his Blue Cross company policy and some on Major Medical. Although he is a participant in my family Blue Cross policy the insurance company is lumping both policies together an implying that the 30 days coverage on my policy is not available to him. He is miraculously better due to the excellent care he is

receiving but he is far from well either mentally or physically. Now the hospital is being pressured by Blue Cross to transfer him to an outpatient basis. If they succeed in this I will have three alternatives: hire a private nurse to stay with my husband, take a leave of absence without pay from my job to be with him; or pick up the $12,000 tab for an extra month's care out of my rapidly dwindling retirement savings. (we are both in our 60's). How can this discrimination against mental illness be ended!"

The above two letters are a sample of those received in response to an ad placed in the Federal Times by the Coalition for Adequate Treatment of Mental Illness, Alcoholism, and Drug Abuse. The coalition, comprised of eleven national organizations (including the APA and the National Alliance of Mental Illness) concerned about the lack of adequate coverage for mental and addictive disorder under the FEHBP, requested federal employees write in about their own personal experiences with the FEHBP. The response was great in number and as you see above, poignant in content.

Critics argue that the mentally ill do in fact have adequate coverage for their health care, if they enroll in the Blue Cross/Blue Shield Service Benefit Plan -- the one plan in the FEHBP with real coverage -- the plan with the highest premium. This practice of adverse selection and the desire to offer coverage to healthy or low risk populations, is a practice strongly criticized in the TPF&C report. The report says it best:

Risk selection is destructive in a group insurance program because it isolates the people who need coverage the most in plans that many of them can ill afford. Since the Government contribution in FEHBP is a specific dollar amount (derived from a formula in the law), risk selection also means that these people pay more for their coverage both absolutely and in percentage terms than do younger, healthier enrollees. Risk selection is also destructive because it means that no plan can offer high levels of coverage in certain critical areas (e.g., mental health, substance abuse, nursing care) for fear of attracting high risk enrollees and ruining the plan's competitive position. Ultimately, risk selection renders the entire program a complex kind of game, in which the winning strategy is to attract healthy people and repel unhealthy ones.

The Federal health insurance program has effectively disenfranchised and financially punished one of the most vulnerable segments of the federal work force -- those in need of treatment for mental illness. While the effects of these discriminatory changes can be evidenced and the argument for change easily articulated, the reasons for why the changes were made are not so easily supported. Most are familiar and all are false.

It is argued that treatment of mental illness is not insurable. That, if provided, then everyone will clamor for them. What apparently has been lost is the concept of health insurance to safeguard against unanticipated, unbudgeted illness, be it physical or mental. Plans of far smaller size with substantially smaller risk pools provide mental

health coverage at the same level as physical illness coverage. They have found that mental health is insurable -- as did the pre-1981 FEHBP.

In addition there is a growing body of literature which has demonstrated the positive cost-benefits associated with the provision of services to the mentally ill, both in terms of lower cost for the treatment of physical disorder, and in terms of worker productivity. In a report conducted by Harold D. Holder, Ph.D. and James O. Blose, M.P.P., the health insurance claims of families covered by Aetna's federal health insurance program, from 1980 through 1983, were analyzed to determine if any changes in total health care utilization and costs were associated with the initiation of mental health treatment. A total of 26,915 families in which at least one member received mental health treatment were compared with a randomly selected group of 16,468 families in which no member had received mental health treatment. While total health care costs for those receiving mental health treatment were significantly higher than costs for the comparison group, those costs dropped significantly after initiation of mental health treatment and continued to decline over the study period. The largest declines occurred among persons age 45 or older.

Another myth is that broad coverage of mental illness leads to abusive, unnecessary or excessive use of the benefit for illnesses that cannot be cured and for extensive treatment for those who are not 'sick'... and that use of psychotherapy is for personal growth, rather than for treatment of specific conditions. The reality is that by

imposing these discriminatory features federal workers and their families who are in genuine need of treatment -- schizophrenics, those suffering from profound depressive disorders, organic psychosis, and other disabling psychiatric illnesses -- are denied adequate care. Studies that survey practitioners show that psychiatric outpatients are moderately to severely disabled, and peer review mechanisms protect against such abuse.

The belief that treatment of psychiatric illness results in few positive results, excessive usage, and little in the way of 'cures', is outdated and uninformed. Scientific research has led to discoveries in brain science that have, and continue to, dramatically alter treatment practices and recovery rates. For instance, we now have an increased capacity to define subgroups of substance abuse and mental disorders that are responsive to particular psychopharmacologic agents coupled with the development of new medications and refinement of existing medications specific to both individual disorders and patient. These activities have helped dramatically decrease the length of patient hospital stays, frequency of illness recurrence, and morbidity among patients suffering from specific severe disorders.

As evidenced above, over the last few years dramatic progress has been made in the areas of research and treatment. As a result, progress, while limited, has also been made on the journey toward non-discrimination and economic protection for the elderly and chronically mentally ill. In OPM's 1987 and 1988 annual "call letters", OPM included in their guidelines a statement on mental

conditions and substance abuse stating:

> "Consistent with our policy of recent years, we will accept no reduction in the level of benefits currently offered in these areas. We encourage modest improvements in these benefits and would be willing to consider them as an exception to the zero cost increase requirement stated above."

In a time such as now, with severe budget constraints and 30 percent rate increases, we are pleased to note that small victories have resulted from OPM's efforts, including no further decreases in coverage and in the case of the Mail Handlers Health Benefit plan, a reinstatement of the outpatient coverage which had been eliminated in 1984. While the package (starting after the second visit, the plan pays $20 per visit with a maximum of $1,000 per calendar year) does virtually nothing for those with little discretionary income suffering from chronic or severe mental illness, it does indicate some willingness to address the problem and perhaps that is the first step towards addressing the issue of discrimination.

The most significant change affecting the FEHBP, was last year's increase in Medicare's mental health benefits. When we offered testimony to your Committee on the effect of Medicare Catastrophic legislative proposals on the FEHBP we noted that the one significant benefit double coverage offered was that it afforded coverage of psychiatric care to federal annuitants and their families at a rate higher than many of the FEHBP plans.

During negotiations for the FY 88 Omnibus Budget Reconciliation Act Congressional leaders were successful in their efforts to increase Medicare's outpatient psychiatric benefit, a provision originally included in the Medicare catastrophic legislation passed in the Senate. Prior to this year, Medicare program outpatient benefits were restricted to $250 annually after coinsurance and deductibles. Inpatient care in a psychiatric hospital is limited to 190 days per a beneficiary's lifetime. Neither of these provisions have been changed since the inception of the Medicare program in 1965. The benefit, as restructured, expands the $250 to $1100 (after an effective 50% copayment), writes into law partial hospitalization guidelines, and allows for medical management of psychopharmacologic agents at 80/20 copayment.

It is now time for all parties ... Congress, OPM, FEHBP carriers, providers and participants alike ... to come to grips with Medicare and its impact on the system, to respond to the changing FEHBP population, to find a way to cope with escalating costs, and at the same time, to provide the quality of care essential to the workforce.

While general consensus is a long way off, there appears to be agreement on one issue. The FEHBP is too big and has become unmanageable. With over 400 options, it seems unlikely that federal employees make well informed decisions each year during the open season and we concur with TPF&C's belief that enrollees are unable to access the relationship between the price and value of various benefits. We believe that while the system is too diverse, it is critical that options continue to exist and that the choices include

fee-for-service and managed care plans. At this point we would like to address what the content of these options have to be to protect those least able to protect themselves, the mentally ill.

There is currently, legislation requiring that mental health care be treated the same as other forms of health care, and that Federal health plans provide copayments and deductibles for the treatment of nervous, mental or emotional disorders at the same level as is required for the treatment of physical illnesses. The bill, H.R. 1734, introduced by Congresswoman Oakar, provides for 50 outpatient visits and 60 inpatient days for the treatment of mental illness, and two 28-day alcoholism and/or substance abuse treatment and rehabilitation benefits. The bill also contains a most important feature which insures that each patient will receive the full treatment which he or she medically requires. Namely, when an established peer review mechanism determines further treatment to be medically or psychologically necessary, these restrictive limitations will be waived. Finally, the legislation requires catastrophic coverage for severe or chronic mental illness.

We believe that these provisions recognize that the majority of patients in need of treatment for mental illness are treated in fewer than 50 visits or 60 inpatient days, and assure that those patients requiring the continued availability of medically necessary treatment will obtain it.

The mechanism to accomplish this is peer review. Psychiatric peer review is a system of professional evaluation, by peers, to ensure

medically necessary care of the highest quality. While peer review is as old as medicine, modern socio-economic developments have given it new significance. Peer review must assure not only the traditional assessment of quality, but must also assume third-party payers and consumers that their health dollars are will spent.

Since 1976, the psychiatric peer review service administered by the APA has been effectively reassuring the insurance industry that treatment of psychiatric illness can be clearly defined and monitored by review procedures. It has shown that the cost of psychiatric treatment is reasonable and predictable, and that the treatment for which the third party provides coverage is medically necessary. The APA's peer review contract now extend to over a score of private insurers as well as to the Department of Defense's CHAMPUS program. The program includes utilization review, quality review and continuing education of psychiatrists as well as consultation with intermediaries to improve both availability of appropriate services and cost management.

The reported cost savings resulting from use of the APA peer review program is impressive. The AETNA Life and Casualty's peer review costs in 1981 were about $20,000 and its estimated savings were $2.4 million. The Mutual of Omaha Insurance Company estimated a savings of between $250,000 and $300,000 in its first year of participation. According to Dr. Alex Rodriquez, former Medical Director of CHAMPUS, the peer review services have led to "outright savings" of between $4 and $5 million per year since participation began. In 1984, peer review "saved" the government over $4.5 million. These are the savings

above the annual cost of the program to CHAMPUS. Additionally, Dr. Rodriguez has said that the quality of records and of patient care itself has increased.

We believe that the combination of peer review with the appropriate benefit, as contained in H.R. 1734, could provide responsible, humane, and cost effective psychiatric care. However, one cannot assume that by requiring care be available participants will have access to care. The APA is concerned that HMO, CMP and other managed care system will through the very nature of their structured financial incentives, limit access to specialty care. The potential underprovision of services for mental and addictive disorders, and the denigration of the quality of those services can only have an adverse effect on patient management and health.

The APA's Coverage Catalog indicates that mental health coverage in federally qualified FEHBP HMO's varies considerable. Of the 155 HMO's participating in FEHBP in 1985, 82 offered the "standard" coverage of 20 outpatient visits per year and 30 inpatient days. Another 44 offered more than 30 inpatient days but only 20 outpatient visits, and only 17 offered an increased (over the 20/30 "standard") outpatient/inpatient benefit.

The reality of an HMO or CMP like structure is that clinical decision-making cannot be completely separate from financial constraints and incentives. Patients with extraordinary medical needs for example, more intensive psychotherapy do not readily "fit in." The TPF&C report concurs with this assessment noting that HMO mental

health coverage is focused on crises intervention and short-term therapy, thereby excluding coverage for serious illness. This new medical - economic reality may mean that the needs of the most severely or chronically mentally ill patients must be met within the limited financial resources of the managed care "low bidder" system, or tragically, not met at all. In the report's review of the HMO Act of 1973 the authors state that HMO "attraction within FEHBP for the younger risks, combined with their failure to attract a proportionate share of the high risks have contributed to the erosion of the group principle and the segmentation of the FEHBP market place according to risk." As a corollary, physicians need not be dependent on their skills to serve patients as a means to preserve their practice. As long as the year-end records indicate they were not overutilizers of services, or that their patients were not overtreated, their future would be fairly secure.

Further, we raise the question whether the limited mental health services provided in these managed care systems are even readily accessible to patients. It appears that in some cases, individuals in need of treatment for a mental disorder are channeled without regard to the medical necessity or appropriateness to non-physicians rather than to psychiatrists, the medical specialist of choice, for the individual patient with concomitant or complicating medical conditions that might cause or exacerbate the demonstrated mental disorder symptoms. Thus, we recommend that, in addition to requiring that the quality of both inpatient and outpatient mental health services provided by a managed care system meets professionally recognized standards of health care including whether appropriate services have

not been provided or have been provided in inappropriate settings, that access to needed psychiatric care by the appropriate provider -- the psychiatrist -- occur.

In conclusion, it is our opinion that several steps must be taken to reform FEHBP in a manner which does not jeopardize the care received by plan participants. The first step has begun. Thanks to the expressed concern of the Subcommittee Chair and his fellow colleagues, OPM has initiated a review; comments are being solicited and support for nondiscriminatory treatment of mental illness appears to be gaining widespread support. The American Medical Association recently reaffirmed existing AMA policy in support of providing insurance benefits for mental illness equivalent in scope and duration to that provided for other illnesses and support continued expansion of peer review of psychiatric services. In addition, the AMA recommended development of model legislation requiring all insurance companies who offer either group or individual health insurance coverage to affirmatively offer coverage of psychiatric services comparable to coverage provided for other illnesses; and support for legislation designed to expand psychiatric benefits provided under publicly financed programs of health care to a level comparable to those provided other illnesses.

The TPF&C report is correct, it has become virtually impossible, given the current structure of the FEHBP, to offer a health plan with a comprehensive benefit structure, at an affordable rate.

We ask that as review continues the Subcommittee considers

implementation of a standard benefit package (as suggested in the report), and force carriers to compete within those parameters, which at the very least, includes the minimum mental health benefit package of 50 outpatient visits, 60 inpatient days and establishes a peer review mechanism. We feel is essential that the package include the concept of medical management and that special attention be drawn to the problem of access to care in a managed-care system. TPF&C believes that had minimum standards been in effect at the beginning of the program, much of the "risk selection" problem would not have occurred. Certainly instituting minimum levels of coverage would ensure universal protection.

The opportunity to address the problem of the Federal Health Benefits Program has been long in coming. We are privileged to have had the opportunity to testify as the conversation begins and welcome the opportunity to respond in greater detail to the recommendations of the report, which due to severe time constraints we are unable to provide you. We have become accustomed to the unfounded charges of our critics stating the outrageous costs of mental health care and have learned to accept them for what they really are. They are statements rooted in prejudice not economic facts. Discriminatory statements against a voiceless, unpopular segment of society twice punished — once by their illness, then by the stigma. Should the opportunity present itself, the APA would be pleased to respond to mental health cost data, data never before presented to us or to the Committee. Perhaps the time has finally come for Congress to address the tragic discrimination entrenched in the current system and find a way to correct the inequities of the past.

Testimony presented to

the Subcommittee on

Compensation and Employee Benefits

by

Bryant L. Welch, Ph.D., J.D.

Executive Director for Professional Practice

on behalf of

The American Psychological Association

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Good afternoon. Mr. Chairman, members of the Subcommittee, I am Bryant Welch, J.D., Ph.D., Executive Director for Professional Practice for the American Psychological Association. I am a doctorally trained psychologist, a Diplomate in Clinical Psychology, and a licensed attorney. Prior to my current position at the American Psychological Association, I spent 10 years in the practice of clinical psychology.

I am here today testifying on behalf of the American Psychological Association. The American Psychological Association, with over 90,000 members, is the major scientific and professional society representing psychology in the United States. Over 40,000 of our members are practicing clinical psychologists. Many of them treat federal employees and retirees through the Federal health program.

Thank you for inviting us to testify today regarding the Federal Employees Health Benefits Program (FEHBP). Mr. Ackerman, I commend you for scheduling this hearing to so closely coincide with the release of the OPM study. It's certainly encouraging that the Office of Personnel Management (OPM) as well as the Subcommittee are conducting such a detailed analysis of the entire Federal health system, and I trust that this exercise will help to outline the need for future congressional and executive reforms. The study appears to make a number of constructive suggestions for changes that could ensure the future solvency of the program, as well as maintain its integrity and further ensure increased access to vital health services by requiring carriers to provide a package of minimum benefits.

I understand that we've been asked to limit our testimony today so that all the witnesses can be accommodated. With that in mind, I'd like to discuss two issues that are of particular concern to our association: first, that federal employees are assured access to mental health services through all available indemnity plans and, second, that mental health benefits and freedom-of-choice of provider be required in Health Maintenance Organizations (HMOs) participating in FEHBP.

MANDATED MENTAL HEALTH BENEFITS

As you know, the Federal health plan does not require its carriers to provide minimum levels of coverage for specific health services - like mental health care. In fact, the just-released OPM study points out that without such a mandate for all plans, there is no incentive for individual plans participating in FEHBP to make coverage available for "critical areas" like mental health because insurers fear the risk of attracting those very individuals who are in need of that care. Thus, the badly needed mental health benefit is trapped in a catch-22 adverse selection problem in which a small number of plans offering an adequate benefit incur a disproportionate share of the claims expense in the mental health area.

State legislatures and other federal programs have long-recognized the need to mandate mental health coverage, and have made a strong policy statements in this regard. For example, twenty-five states have passed mandate bills requiring minimum coverage for mental illness and/or alcohol,

drug abuse. Beyond mandates for inpatient services, most states have further mandated outpatient and day treatment in an effort to make available a more cost-effective alternative to inpatient care. These laws have been enacted despite strong opposition of the insurance industry and the business community who claimed that costs would rise uncontrollably if such laws are enacted. In fact, businesses and insurers have not experienced these predicted losses. Instead, studies looking at the impact of mandated mental health benefit laws clearly demonstrate cost-effectiveness of such laws.

To illustrate, in 1983, the State of Oregon passed a bill that greatly enhanced services for chemical dependency and mental illness in less costly outpatient treatment settings. They anticipated that more people would seek mental health care in these outpatient settings. In addition, they believed that a cost savings would result from covering these less expensive, yet appropriate services. Both of these predictions came true, enabling more people to obtain services while meeting or exceeding estimated cost savings.

Blue Cross/Blue Shield (Oregon's largest private insurance carrier) showed that total costs of claims increased insignificantly, despite an increase in the volume of claims after enactment of the mandate bill. More costly, inpatient reimbursement dropped substantially for Blue Cross/Blue Shield. Other insurers have documented similar experiences after a mandated mental health benefit law was enacted in their state. For example, one Blue Cross/Blue Shield carrier showed that after the enactment of a mandated mental health benefit law, the monthly cost per patient for medical services

dropped from $16.47 to $7.06 for those patients who received mental health benefits. Inpatient and outpatient medical visits decreased by more than 54%. We believes this experience would be similar on the federal level for FEHBP.

These and other studies clearly demonstrate the cost-effectiveness of having appropriate mental health coverage available, and the role that mental health intervention plays in offsetting the use and consequently, cost of unnecessary medical care. This data become more clear when we are reminded of the little known fact that approximately 60% of all health care visits to physicians are by people with no physical problem. This figure rises to 80%-90% when stress-related illnesses are also included. We believe that available and appropriate levels of mental health care would eventually reduce the inappropriate use of more expensive and unnecessary medical services.

Mandating mental health benefits is a reasonable federal policy based on all of reasons mentioned. It is also important as lawmakers to be aware of the serious need for mental health services among our citizens. This is most dramatically illustrated by looking at the resources our nation is expending on the treatment of mental illness, the price we pay in real dollars for not treating these disorders. A study conducted by the National Institute of Mental Health indicates that mental disorders, alcohol and substance abuse account for over $50.3 billion in direct care costs, and $162.4 billion in indirect losses due to mortality, high absenteeism, low

productivity, and loss of employment. These figures clearly demonstrate that we cannot afford to ignore mental health care in this country any longer.

The American Psychological Association strongly believes that mandating mental health coverage is sound health policy, and offers minimal investment against the kind of losses that our country's public and private sectors are experiencing as a result of inadequate or unavailable mental health care. We, as part of a coalition of a number of other national organizations concerned with the availability of adequate mental health care, have offered this Subcommittee in previous years our recommendations for a standard, minimum mental health benefit package. Our recommendations also contain proposals to ensure utilization and cost controls. These recommendations will be put forth in testimony that will be submitted for the record on behalf of the coalition. We strongly urge you to consider these recommendations, and to enact an amendment to FEHBA to mandate coverage of mental health care for federal employees.

MENTAL HEALTH CARE IN HMOs

A second area of concern to the APA, also mentioned in the OPM study, is the impact of HMOs on the availability of mental health care to federal employees. We wish to emphasize first that our concerns are not directed to the concept of HMOs, but rather to their current operations within the FEHBP program. Second, we acknowledge the HMO industry's argument for the

freedom necessary to achieve their primary mandate, i.e., to reduce costs through the elimination of unnecessary services. Unfortunately, however, the easiest area to reduce costs for HMOs is in a badly needed service area — that of mental health care. Since the inception of the HMO movement, those of us in clinical practice have recognized many de facto barriers to proper mental health care within the HMO system. Specifically, these barriers include using gatekeeper providers such as general physicians who have inadequate mental health training to begin with, who are operating under strong financial incentives not to refer for appropriate care, and who, too often, have a clear personal bias against patients in need of such care. The data is now supporting these clinical observations as we find that the typical HMO is reported to spend only three percent of its already reduced health care budget for mental health care as opposed to the eight percent figure of the traditional delivery system.

Accordingly, we strongly support the OPM recommendation that stronger consumer protection standards be applied to HMOs in their delivery of mental health services through the FEHBP program. Specifically, we recommend the following:

1) Truth in packaging — specifically, FEHBP HMOs should be required to explain to prospective enrollees the financial arrangement which exists between the gatekeeper physician and the HMO so they can be sufficiently knowledgeable to protect their interest in negotiating care with the HMO and their gatekeeper physician.

2) Direct access to a qualified mental health professional for evalutations. Studies indicate that the average medical school graduate has only the most limited training in mental health care and that most of this is done in inpatient settings. The diagnostic skills of psychologists, psychiatrists, and other qualified mental health providers is crucial if the mental health benefit is to be appropriately utilized. Accordingly, we strongly recommend a provision for patients to have the gatekeeping function preserved but fulfilled by a qualified mental health professional.

3) Freedom of choice of provider class — many HMOs are physician dominated and seek to restrict patient care to physicians. These provisions fly in the face of the well-established FEHBP preference for permitting consumer access to a range of providers because of the lower cost they represent and because of the wider range of services they are able to provide. Currently, the HMO industry is permitted to escape this very important principle much to the detriment of federal employees enrolled in HMOs. Accordingly, we recommend that HMO panels be required to utilize providers from different mental health professions so that this advantage can be maintained throughout the FEHBP system. Limiting enrollee access to the highest priced providers or to those who are untrained in mental health care clearly defeats FEHBPs purpose of providing access to affordable, high quality care.

On behalf of the American Psychological Association, thank you for your interest in searching for ways to significantly improve the Federal

Employees Health Benefits Programs. We appreciate the opportunity you have given us to address our concerns, and look forward to working with you to correct some of the deficiencies in the system that we have pointed out today.

SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS

COMMITTEE ON POST OFFICE AND CIVIL SERVICE

UNITED STATES HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING ON FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STATEMENT OF:

LAWRENCE Y. KLINE, M.D.

COALITION FOR ADEQUATE MENTAL HEALTH,

ALCOHOLISM AND DRUG ABUSE SERVICES

May 11, 1988

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Mr. Chairman, members of the Committee, I am Lawrence Y. Kline, M.D., a physician in the private practice of psychiatry and a former president of the Washington Psychiatric Society. I appear today on behalf of the Coalition for Adequate Mental Health, Alcoholism and Drug Abuse Services.

The Coalition is comprised of patient-based community organizations and associations representing several thousand professionals in the Greater Washington Metropolitan Area who treat and care for victims of mental illness and those suffering the ravages of alcoholism and drug abuse. Many if not most of our patients are federal workers covered by the federal employee health insurance program.

Our coalition is dedicated to providing adequate levels of care for the mentally ill and for those afflicted with alcohol and drug related diseases. We have been successful in helping to achieve these goals in the District of Columbia and in Maryland. In 1986, the District Government adopted the most far reaching reform in addressing the health care needs of the mentally ill and of those suffering from alcoholism and drug abuse. Adopted were requirements leading to an end to the discriminatory insurance coverage of these afflictions. All group health policies issued within the District -- save those coming under the FEHBP umbrella -- must now comply. In effect, this includes providing coverage for outpatient care and/or hospitalization whenever medically necessary.

Mr. Chairman, when compared to this District law and to the laws in Maryland and elsewhere requiring adequate levels of coverage for mental and related illnesses, the FEHBP is simply inadequate. It discriminates. For this patient

group we serve, the FEHBP plans generally fail miserably in meeting minimum standards of medical necessity.

It is easy therefore to sum up our views. The FEHBP must be redesigned to meet the basic essentials of treatment for the patient community we serve. Mentally ill federal workers and their dependents, workers addicted to alcohol and other debilitating substances and older federal annuitants have been singled out and discriminated against. Well documented also has been the Program's gross inefficiency stimulated by its fragmented and apparently uncharted growth and the wasteful proportions of its bloated costs and expense.

We hope to have at last found encouragement in the report of the Towers, Perrin, Forster & Crosby study. But we remain skeptical. To that end, the major questions for us include the following:

(1) Does the report address the discrimination suffered by those seeking to end their alcohol and drug dependency? Does it address the basic coverage inequities imposed against victims of serious mental and nervous disorders -- of schizophrenia, chronic depression and suicide?

(2) What does the report say about plans covering only those benefits that sell in the marketplace while ignoring illnesses such as mental illness which may often still be enshrounded by misinformed stereotypes?

(3) Are the plans designed only to attract the healthiest workers? If so, what are the implications for seriously ill victims in need of long term care? Must taxpayer-supported institutions be the last resort for the chronically ill?

(4) Finally, if it is correct that the notion of adverse selection precludes any one plan from offering adequate mental, drug and alcohol benefits, why then hasn't the Congress long ago insisted that the risk be spread to all the federal plans?

In sum, with the Towers, Perrin report, we hope that the blueprint for change and reform has begun to emerge. But most of all we urge that Congress end the discrimination and begin to restore victims of mental illness and related afflictions to a position of legitimacy within the federal health insurance scheme. As all present here know, benefits for them were the subject of cutbacks by the Office of Personnel Management beginning seven years ago. These were arbitrary cuts. Never explained. Never justified. And targetted at those individuals who are perhaps most vulnerable and least powerful.

Sadly, most workers do not even know that their health insurance does not cover mental illness until it is too late. There was never a vocal public uprising against past moves by OPM. Those who don't need the insurance ignore the problem. Those who do often are too sick to effectively mobilize an effort to protest.

Nevertheless, when people get sick, they must have treatment. If uninsured, they either find themselves seeking to pay catastrophic costs out of pocket, or else the taxpayers end up footing the bill. Moreover, inadequate treatment for nervous, mental and similar disorders results in hidden costs including broken homes, child abuse, alcoholism, reduced productivity, increased use of other medical facilities, disability, chronicity of otherwise treatable illnesses and death from suicide -- the third leading cause of death of young people in the U.S.

Mr. Chairman, you are to be commended for your role in focusing national attention on this suicide crisis involving our nation's youth. Similarly, you, as much as anyone, appreciate the consequence of the failure to provide adequate psychiatric coverage. It simply saddles the taxpayers with an ever increasing fiscal burden.

Scientific studies have shown time and again that symptoms of chronic mental illness, such as apathy or the inability to take initiative, often are the result of inadequate treatment. These symptoms render such patients totally disabled and place them on welfare rolls to become part of the enormous hidden costs of inadequate coverage of mental illness treatment. These studies and related clinical experience reveal that patients who break down "permanently," who are repeated criminals, who have multiple illegitimate pregnancies, commit child abuse,

traffic in drugs or develop alcoholism -- these people often have adolescent histories of trouble and emotional conflict or have close relatives who sufferred from diagnosable and inadequately treated psychiatric illness. These are some of the reasons why an effective FEHBP must be redesigned to insist on non-discrimination in the coverage of mental illness, alcohol and drug abuse. The past failure to do so has had tragic consequences.

Because many residents of metropolitan Washington are federal workers or their dependents, providers of care here -- members of our coalition -- see many of these traumatic and even fatal consequences. We have heard from them. We have collected and compiled their first-hand accounts. We wish to share with this Committee the human misery caused by discrimination in federal insurance. That misery is manifested in case histories -- letters appended to my testimony. The names and details have been sanitized to protect patients. However, what these first-hand accounts show is the terrible effects of inadequate and discriminatory coverage. One letter reads as follows:

> "Two years ago my adolescent daughter, away at college, made a serious suicide attempt. She needed a full year of hospitalization at a private psychiatric hospital. My coverage under NALC, however, provided for only eight months of coverage and that with a copayment of $7,000. This represented a catastrophic expense to me as a divorced mother earning $13,000 a year at my government job; however, my 'catastrophic' coverage did not seem to extend to this expense . . . I am distressed to realize that my NALC coverage will pay for lifesaving heart and liver transplants but no more than a $50,000 lifetime total for what can also be lifesaving treatment in a psychiatric hospital."

Such documented inequities involving federal workers are not so apparent in the private business sector. Recent surveys conducted even before the effective date of the D.C. law show the following regarding business and organizations representative of a cross-section of large employers:

-- 72% of the plans which provide outpatient psychiatric coverage place no limits on the maximum number of visits -- unheard of within the FEHBP;

-- 92% of the plans provide for outpatient psychiatric coverage -- far more than the FEHBP;

-- 47% of the plans covering outpatient psychiatric expenses have no dollar maximum other than that for the overall major medical plan;

-- 69% provide the same coverage for in-hospital doctor expenses for psychiatric care as for other confinements;

-- 57% provide the same coverage for routine services of inpatient psychiatric care as for other confinements -- unheard of within the FEHBP;

-- 30% of the plans -- not enough -- have alcohol and drug assistance programs.

From a survey of 300 private sector health insurance plans we know that numbers of major corporations which were surveyed -- large employers -- provide for no distinction between the coverage of physical and mental illnesses. These include the

Quaker Oats Company with over 40,000 employees, Phillip Morris, Inc. with over 70,000 employees, Knight Ridder Newspapers, Inc. with nearly 20,000 employees and Eli Lilly & Company with just under 30,000 employees.

Finally, The Washington Business Group on Health, whose members provide health and medical insurance benefits for some 55 million workers, retirees and dependents, has found after extensive research, "There is no way to avoid the cost of mental illness . . . thus business leaders are increasingly convinced that paying for prevention and early detection is a wise business investment."

Why, in light of all of this evidence from the private sector, do federal policy makers decide to severely limit mental and nervous treatment in health insurance coverage? One fear often voiced to us is that the number of people who would use these services would soar without specific caps on treatment. Yet during 12 years of experience with the federal plan, costs of Blue Cross/ Blue Shield mental health services remained at a relatively stable 7.5 perecent of total health costs at a time when treatment was limited only by medical necessity and not by some arbitrary ceilings established by OPM. Blue Cross/Blue Shield advised me about a year ago that this utilization rate for mental services had dropped to about 4 percent.

More and more private plans are realizing the value of adequate mental health treatment and are incorporating it into their employee benefit plans. Meanwhile, the federal government has persisted in moving in the opposite direction or in standing pat. Yet, study after study conclude that based on employee contribution and benefits offered, federal workers fare worse than their private sector counter-parts. In particular, coverage for mental, nervous and substance abuse treatment, whether on an in- or out-patient basis, was judged inferior.

There is simply no reason for this discriminatory treatment under the FEHBP. Today's prognosis for the mentally ill is at least as promising as that for other important diseases, such as some types of cancer. About two-thirds of all psychiatric patients will show significant recovery, and of these, half will never need treatment again.

Unfortunately, there is still a stigma and much fear associated with mental illness. Third-party payers have no difficulty reimbursing for treatment of a variety of conditions where the diagnosis may be precise, even though treatment effectiveness is questionable. With a "broken mind," however, questions are continuously raised about observable diseases, clearly defined treatment and reliable prognoses.

Mr. Chairman, it is time this committee acts to redress this overwhelming inequity and make immediate action an essential

priority. For too long mental illness, drug and alcohol dependency have been left to linger at the bottom when it comes to the priority list of the federal insurance program. About all that has been obtained in recent years is the admonition by OPM to the Plans not to cut deeper into mental benefits.

That is not enough. It is too little and too late. Bills such as H.R. 1734, by Congresswoman Oakar and its predecessor versions should be considered as soon as possible. They seek to address the issue of discrimination head on. Some mechanism, for example, simply must be imposed to include in the federal plans a level premium option with non-discriminatory mental health and substance abuse coverage. The case is unassailable. It is not enough to provide 10 or 20 outpatient treatment visits at the reimbursable rate of 50%, which is the most coverage available to a chronically depressed teenaged child of a federal worker on the brink of suicide. The average group plan in this area is better suited to address his or her basic medical needs. Most area self-insured companies such as C & P, Pepco and Marriott provide greater benefits by spreading the risk and keeping premium costs in check.

At the very least, Mr. Chairman, OPM can begin to require -- and Congress can insist -- that the plans consider offering supplemental benefits to bring coverage up to comprehensive levels; even if workers have to pay the difference.

Also, mental and related benefit strategies in the federal insurance system should be designed to encourage a

professional provider to determine the most effective and least restrictive form of treatment. To do so means establishing actuarial equivalent standards so that, for example, the dollar value of services may be available whether the treating professional adopts one treatment setting -- a hospital -- or another -- a clinic or an office.

Finally, our coalition encourages access to care within the FEHBP. In that regard, the consumer freedom of choice of provider mandate currently exempts group model HMO's. Our coalition is opposed to expanding the exemption for "managed care" which further restricts consumer access to providers of their choice.

Mr. Chairman, we welcome these hearings. While we are encouraged, we remain skeptical. Thank you.

[redacted]
Gaithersburg, MD 20879
November 14, 1986

Coalition for Adequate Treatment of
Mental ILlness, Alcoholism, and Drug Abuse
P.O. Box 65282
Washington, D.C. 20035

Gentlepersons:

This letter is in response to your recent ad in Federal Times concerning current benefits under FEHBP for mental illness, alcoholism, and drug abuse; I support increased benefits.

I have had a problem with inadequate psychiatric coverage. Two years ago my adolescent daughter, away at college, made a serious suicide attempt. She needed a full year of hospitalization at a private psychiatric hospital. My coverage under NALC, however, provided for only eight months of coverage and that with a copayment of $7,000. This represented a catastrophic expense to me as a divorced mother earning on $13,000 a year at my government job; however, my "catastrophic" coverage didn't seem to extent to this expense. Fortunately, my former husband was able to secure coverage for the remainder of our daughter's hospitalization and for her outpatient treatment since. She is now doing well in her studies at a Baltimore college and is happily engaged in many extracurricular activities as well. However, I am distressed to realize that my NALC coverage will pay for lifesaving heart and liver transplants but no more than a $50,000 lifetime total for what can also be lifesaving treatment in a psychiatric hospital.

Sincerely,

[redacted]

[redacted]
WEST [illegible]

COALITION FOR ADEQUATE TREATMENT OF
MENTAL ILLNESS, ALCOHOLISM + DRUG ABUSE
P.O. BOX 65282
WASHINGTON, DC 20035

IT PLEASES ME TO KNOW THAT THERE IS AN ORGANIZATION WORKING TO IMPROVE TREATMENT OF MENTAL ILLNESSES AND TO UPGRADE HEALTH INSURANCE COVERAGE FOR SUCH TREATMENT.

I HAVE BEEN RECEIVING PSYCHOTHERAPY AND PRESCRIPTION DRUGS FOR TREATMENT OF DEPRESSION FOR OVER 5 YEARS AND IT DISTRESSES ME THAT HEALTH INSURORS ARE RELUCTANT TO PROVIDE BENEFITS ON A PAR WITH PHYSICAL AILMENTS.

MY HEALTH INSURANCE IS BC/BS STANDARD OPTION. I AM [illegible] THAT IT PROVIDES MENTAL HEALTH BENEFITS. SOME PLANS PROVIDE [illegible] ANYWAY BC/BS STANDARD OPTION HAS A $250 DEDUCTIBLE REQUIRE. FOR 2 MEMBERS OF THE FAMILY AND UNTIL RECENTLY PAID ONLY 70% FOR MENTAL HEALTH EXPENSES. NOW I SEE [illegible] WAS REDUCED FOR 1987 TO 60%.

HOWEVER TO OFFSET THAT INCREASE IN COST TO ME, [illegible] IMPLEMENTED A MAIL ORDER DRUG PROGRAM. A 90 DAY SUPPLY OF MEDICATION BROUGHT THRU THE MAIL COSTS ONLY $5 NOW.

[illegible] CONCLUSION, I SPEND A LOT OF MONEY OUT OF MY [illegible] [illegible] FOR MY [illegible]. [illegible]
[illegible]
[illegible]

[redacted]
Arlington, VA 22206
5 Mar 87

CAMADAS
1400 K Street, N.W.
Room 202
Washington, DC 20005

Gentlemen:

I wish to express my objections to the serious and unwarrented reduction in the psychological coverage of federal health plans. It is a terrible burden on families, particularly those with children. With the growth of two income families brought about by the recent long and severe inflation and the failure of salary rates to keep up and catch up with it, psychological problems have become if anything more serious than they were in the past.

I belong to the Blues, and I know they maintain a double standard, as does Medicare, between psychiatric illnesses and all others. I have standard coverage. Psychiatric treatments are limited by Blue Shield to 25 a year, and the amount of payment to 60% as against a regular payment of 75%. It is not fair. If I go to a medical specialist, say an orthopedist, the specialist may see me for no more than ten minutes, have a technican give me two or three X-Rays, and I might perhaps receive a shot of cortisone. The bill can come close to $200, and Blue Shield may pay all or most of it.

On the other hand, if I have an adolescent child who suffers severe anxiety attacks and may tend toward depression, the cost to me can be enormous. Psychiatric help is absolutely essential. On a time basis, the psychiatrist receives and charges less than any type of specialist one may mention. But just because it is for his time that he is paid, his services are allowed less repayment than anyone else. There are many other time-consuming illnesses, with much less positive prognoses than mental illnesses, that are not treated in this discriminatory fashion.

Very truly yours,

[redacted]

3/11/87

Mr Alan Colub
Washington, D.C.

Dear Mr Colub;

I feel Federal program of employees on drug abuse and mental illness is very inadiquat.

It seems the administration talking one way the awareness of employees and general public of this problem is good. On the other hand they are giving refunds to some of the insurance carriers because of surplus of funds.

This has been confusing to me. I am a retired Federal employee

Sincerely

[redacted]

[redacted]
Washington, D.C. 20003

1/21/87

Coalition for Adequate Treatment
of Mental Illness, Alcoholism, and
Drug Abuse
P.O. Box 65282
Washington, D.C. 20035

Dear Sir,

Can you please send me, some details on the new bill that was past 1985 Bill 6-195
I Need health insurance because I am a drug and alcohol abuser and I feel that is the best thing for people like myself.

[redacted]

Thank you,

[redacted]

[redacted]

CANADAS
1400 K Street, N.W.
Room 202
Washington, DC 20005

Gentlemen:

I wish to express my objections to the serious and unwarrented reduction in the psychological coverage of federal health plans. It is a terrible burden on families, particularly those with children. With the growth of two income families brought about by the recent long and severe inflation and the failure of salary rates to keep up and catch up with it, psychological problems have become if anything more serious than they were in the past.

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On the other hand, if I have an adolescent child who suffers severe anxiety attacks and may tend toward depression, the cost to me can be enormous. Psychiatric help is absolutely essential. On a time basis, the psychiatrist receives and charges less than any type of specialist one may mention. But just because it is for his time that he is paid, his services are allowed less repayment than anyone else. There are many other time-consuming illnesses, with much less positive prognoses than mental illnesses, that are not treated in this discriminatory fashion.

Very truly yours,

[redacted]

[redacted]
Chelmsford, MA 01824
December 17, 1986

Coalition For Adequate Treatment of Mental
Illness, Alcoholism and Drug Abuse
PO Box 65282
Washington, D.C. 20035

Dear Sir:

I agree with your goal of halting discriminatory insurance coverage for mental illness, alcoholism and drug abuse. I am the victim of less than adequate coverage for mental illness. We now know that the causes of mental illness are physical in nature, but our insurance coverage is less than for the established definition of physical illness.

I want to suggest that perhaps the subjects of mental illness, alcoholism and drug abuse be treated separately for medical insurance coverage purposes.

Please let me know how you want me to question my current benefits, and if there is anything else I can do.

Yours truly,

[redacted]

NOV. 25, 1985

Coalition for Adequate Treatment
Of Mental Illness, Alcholism, & Drug Abuse
P.O. Box 65282
Washington, D.C. 20035

To Whom It May Concern:

I am writing you in concern of mental illness. I have been hospitalized twice in the last four years (1982, 1985) and have been stuck with medical bills of $1700.00 and $5200.00

In 1982 I was covered under American Postal Workers Union insurance and they paid all but $1700.00 In 1985 I had Mailhandlers Plan Insurance and was stuck with the $5200.00 bill in which I still am paying on.

I am writing this letter as I saw your advertisement in an issue of Federal Times

Sincerely,

[redacted]

[redacted]
Watertown, CT 06795-1310
November 12, 1986

Coalition for Adequate Treatment
of Mental Illness, Alcoholism and Drug Abuse
P O Box 65282
Washington D.C. 20035

Dear Sirs:

I am a postal employee now for 4.5 years. My son was a teenager when I became an employee and he did get involved with drugs and became an abuser. There was no plan that offered me mental treatment or drug abuse treatment that could help me. Drug abuse is not considered short-term or a crisis to be treated with six visits or whatever the different similar restrictions are in the health plans offered by the Federal Government.

It may be true that everyone should not pay a high premium for some others' high-costing treatments but perhaps a "level-3 option" or some other phrase could be offered to people who are willing to pay the premium say through the ages their children are preteen through teen just like some people are willing to pay for a higher premium for well-baby care.

Let us choose if we want coverage for this and tell us what we would have to pay for it.

I think the same holds true for chiropractic care. I would pay a heftier premium if the coverage was available but it is not available except in a small amount (limited to so many visits per year) on a couple of the plans.

By the way, my son is now 21 and married. He has many problem which I feel he would not be carrying with him if he had been able to get help (which I could not afford without some kind of insurance assistance) during his earlier years.

Sincerely,

[redacted]

[redacted]
Silver Spring, MD 20910
November 17, 1986

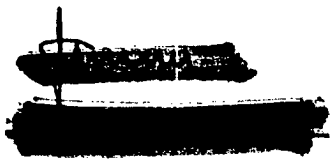
Coalition for Adequate Treatment
P.O. Box 65282
Washington, DC 20035

Gentlemen:

I wholeheartedly agree with your ad in this week's Federal Times: mental health coverage is quite poor for Federal employees. I don't know of one health benefit plan which provides adequate coverage, particularly for outpatient treatment. I agree with you that mental health benefits should be approximately the same as for physical care.

Good luck in your campaign!

Sincerely,



[redacted] [illegible]
[illegible]

Coalition for Adequate Treatment
of Mental Illness, Alcoholism and Drug Abuse

[illegible] 65282

Washington, D.C. 20035

Dear Sirs and Madams,

I was pleased to have the good luck to see your advertisement in the Federal Times. [illegible] adequate coverage for mental illness is a problem.

Enclosed is a copy of correspondence I have had with the American Federation of Government Employees [illegible] insurance carrier. Dr [redacted] is an obstetrician who performed a D+C on my wife during a hospitalization ([redacted]). The other physicians performed a [illegible] for mental illness. The D+C procedure itself was done [illegible]. [illegible] the insurance company paid for that [illegible] and [illegible] correspondence [illegible] itself.

I wish you success in your [illegible] [illegible] sorely needed.

Also, if there is a better insurance plan [illegible] I'd like to know about it during open season.

Sincerely yours,

[redacted]

[redacted]
Bowie, MD 20716
November 14, 1986

Coalition for Adequate Treatment
Of Mental Illness, Alcoholism, and Drug Abuse
P. O. Box 65282
Washington, D. C. 20035

Dear Sirs:

I wrote a letter to you dated November 13 in which I said my Blue Cross policies only provided 30 days (each) for hospitalization for mental illness and that it was a life-time restriction. I was in error. It is 30 days coverage per year.

Please, please do all you can to have these discriminatory provisions changed!

Sincerely yours,

[redacted]

[redacted]
Bowie, [redacted]
November 28, 1986

Coalition for Adequate Treatment
of Mental Illness, Alcoholism, and Drug Abuse
P. O. Box 65682
Washington, D. C. 20035

Dear Sirs:

In response to your advertisement in the Federal Times, I wrote two letters to you. If you are keeping those letters on file please add this one to it.

My husband is currently a patient at Sheppard-Pratt Hospital in Baltimore. He has had 30 days care on his Blue Cross company policy and some on Major Medical. Although he is a participant in my family Blue Cross policy the insurance company is lumping both policies together and implying that the 30 days coverage on my policy is not available to him.

He is miraculously better due to the excellent care he is receiving but he is far from well either mentally or physically. Now the hospital is being pressured by Blue Cross to transfer him to an out-patient basis. If they succeed in this I will have three alternatives: hire a private nurse to stay with my husband, take a leave of absence without pay from my job to be with him; or pick up the $12,000 tab for an extra month's care out of my rapidly dwindling retirement savings.(We are both in our 60's).

How can this discrimination against mental illness be ended!

Sincerely yours,

[redacted]

[redacted]
Bowie, MD 20716
November 13, 1986

Coalition for Adequate Treatment
Of Mental Illness, Alcoholism, and Drug Abuse
P. O. Box 65282
Washington, D. C. 20035

Dear Sirs:

You cannot imagine the relief I felt when I saw your advertisement and realized that someone was doing something to correct the terrifying restrictions placed on mental health coverage by all hospitalization plans.

My husband is currently a patient in Sheppard-Pratt Hospital, Towson, Maryand. His condition was diagnosed as pyschotic depression. His Blue Cross policy and my policy (in which he is a participant) will only pay fully for 60 days treatment - and my understanding is that this is a one-time, lifetime provision. After the 60 days are up (and they are deducting 9 days that he spent as a medical patient in Anne Arundel General Hospital prior to transfer to Sheppard-Pratt) they will only pay 80% of the basic charge which will leave me with the choice of returning him to home only partially cured or absorbing a charge of approximately $2000 per month which does not include any special treatments, care or physician's fees!

My understanding is that once he is dismissed he can never receive hospitalization assistance again. If he becomes ill once more it would ruin us financially to try to hospitalize him to receive the treatment he would need.

This is so outrageously unfair! If it were his heart or a hernia or a blood disease he could be treated again and again but because it is mental illness we must live in fear not only of a recurrence but of financial catastrophe.

Whatever support I can lend to your effort to remove the stigma and prejudice toward mental illness in the health insurance industry I will give gladly!

Sincerely yours,

[redacted]

November [illegible]

Coalition for Adequate Treatment
of Mental Illness, Alcoholism & Drug Abuse
PO Box 65282
Washington DC 20035

Dear Sir:

I'm a federal employee and had what I thought to be the BEST in health insurance, [illegible] cost enough (Post Masters for family)

I had no idea I was an alcoholic — I knew I drank too much but really had no education on the subject. I received a "DWI" [illegible] years ago & was told to go for treatment and since I worked I had to pay. Can you imagine my shock and grief at the mounting bills — plus I [illegible] my leave — (6 week program) [illegible] [illegible] I will be in debt forever. Alcoholism [illegible] disease — like diabetes and should definitely [illegible] covered. My bills are enough to send [illegible] person out drinking again but I don't [illegible]

Sincerely

[redacted]

II

the insurance companies should be more aware of this.

I would also like to say that the doctors dont help to keep to cost of the servis down either.

Sincerely,

[redacted]

Ord, Ne. 68862

Ord, Ne.
Nov. 12, 1986

Dear Sir,

I would like to say that the coverage for mental illness, alcoholism and drug abuse. is not very good.

It would seem to me that it should have better coverage. for the very simple reason that there shouldn't be a difference in what they will pay on what the insurance

Any of the above illness are part of a human being. There are very important for are well being.

Any one can have these illnesses without knowing it.

[redacted]

Brooklyn NY [illegible]

11-22-86

To Mental Health Coalition Wash. DC 20035

Sirs,

I very happy to hear that finally someone organize to raise an outcry about the draconian cuts on Mental health imposed by the Reagan adm. We pay hefty insurance premiums as Federal Workers and yet have no peace of mind if someone suffers god forbid a breakdown and requires hospitalization at $500-600 per day with required 50% co-payment. how could we underpaid Federal Workers cope with it to raise $8000 catastropic protection, I am now being sued by [redacted] Hospital in Brooklyn for over $2000 - and I have a date in Court [redacted] 12-2 [illegible] I was overseas when someone in my family fell ill and the bill for 1 WK stay came to [illegible]250 of which the health plan ~~paid~~ paid only $1700. I would never allow the [illegible] my family to be admitted [illegible] [illegible] compared with New York State

Declassified in Part - Sanitized Copy Approved for Release 2013/01/14 : CIA-RDP90M00005R001000100010-4

11/17/86

DEAR SIR;

THIS REPLY TO YOUR ADD IN FEDERAL TIME.
NOV. 24, 1986.

YES FEDERAL AND FEDERAL RETIRES
ARE BEING DISCRIMINATED AGAINST.

THE FEDERAL INS. PROGRAM IS VERY
INADEQUATE COVERAGE.

WHAT AMAZES ME IS ADMINSTRATIO
IS ADVOCATING TREATMENT FOR ALCOHOL
AND DRUGS OUT ONE VOICE AND THERE
IS NO COVERAGE FOR DRUGS AND MENTAL
ILLNESS.

PLEASE CONTINUE THESE ADS
BECAUSE MANY FAMILIES WILL FALL THRU
CRACKS FINANCIALLY.

YOURS TRULY

that requires Mental health Coverage
on Medicare Medicine plans but federal
law over rules it. I willing to help
raise an outcry about such unfairness
the bigger problem that the 50 o/o Copay
is unfair to many health plans
as if acting in concert to deny Mentally
Mentally Ill benefit.

Very Truly yours

STAT

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Changes in Health Care Costs and Utilization Associated With Mental Health Treatment

Harold D. Holder, Ph.D.
James O. Blose, M.P.P.

Health insurance claims of families covered by Aetna's Federal Employees Health Benefit Program from 1980 through 1983 were analyzed to determine if any changes in total health care utilization and costs were associated with the initiation of mental health treatment. A total of 26,915 families in which at least one member received mental health treatment were compared with a randomly selected group of 16,468 families in which no member had received mental health treatment. Total health care costs for those receiving mental health treatment were significantly higher than costs for the comparison group. However, those costs dropped significantly after initiation of mental health treatment and continued to decline over the study period. The biggest declines occurred among persons age 45 and older, a finding that may have important policy considerations.

While mental health care could be seen as adding to the overall cost of general health care, there is growing evidence that mental health care actually results in lower total heath care utilization and costs for treated persons. This can be the result even when the cost of mental health care itself is included. Follette and Cummings (1), in

viduals who were stratified by age to match the age distribution of the mental health study group. Families with any member receiving treatment for alcoholism or drug abuse were excluded from both the comparison group and the mental health study group.

The ideal research design for determining statistically significant changes in total health care patterns would use experimental treatment and no-treatment control groups randomly assigned from the same population. However, the identification of a diagnosed but untreated group is impossible in a large field study utilizing health insurance claims as a means to identify the treatment population.

An alternative is a quasi-experimental design that utilizes a nonequivalent comparison group as well as multiple pretests and posttests (11,12). A pre-post design was used to compare pre-mental-health-treatment averages over various time periods with averages after initiation of treatment.

Since the comparison group is a nonequivalent one, it can be used only for baseline comparisons with the mental health treatment group.

In addition, a longitudinal analysis that pooled available data from all individuals was used to describe long-term patterns. The pre-post analysis permits reliable testing for statistically significant changes in cost and utilization. The longitudinal analysis permits use of all the available data to document long-term trends and tendencies.

Comparison of the groups

The mental health study group and the comparison group were quite similar in average family age, family size, and type of health insurance plan option. The average family size for those with at least one member receiving mental health care was 2.57 persons, compared with 2.54 persons in families in the random sample. The average family age (as of January 1984) was 48.8 years for the mental health treatment group and 49.2 years for the comparison group. The same percentage of both groups (79 percent) were enrolled under high-option coverage.

The monthly per-person costs (in January 1980 dollars) for all health care for families with at least one member receiving mental health treatment were $158.82, compared with $91.85 for the random sample. Most of this difference was the result of inpatient treatment costs ($104.85 a month for the mental health treatment group versus $60.12 a month for the random sample). However, there were also differences between the two groups in ambulatory care and other costs over the four-year study period.

The families with at least one member receiving mental health treatment averaged .39 inpatient days per person per month compared with .18 days for the random sample. Mental health treatment costs amounted to $22 per month, or 14 percent of the $159 average monthly costs for all health care for persons in the mental health study group, thus indicating that these cost differences are not due primarily to the cost of mental health treatment. All of these comparisons were statistically significant at $p<.001$. In point of fact, given the relatively large treatment group and comparison group sizes utilized in this study, most differences were statistically significant.

Mental health treatment costs and utilization

During the 1980–83 period, those in the continuously enrolled population who filed mental health treatment claims were largely female (60.6 percent). The mean age was 45.3 years but varied widely. More than 16 percent of the group were under 21 years old and 23 percent were 65 and over. Forty-five percent of the group were enrollees (federal employees or annuitants), 33 percent were spouses, and 22 percent were dependent children. Less than 1 percent were other dependents.

The cost of mental health care per person receiving care during the study period was $2,079 (January 1980 dollars), of which 63.4 percent was paid by Aetna as health insurance benefits. Inpatient care, though utilized by only 20 percent of the mental health patients, accounted for 60 percent of mental health treatment costs. The average length of inpatient mental health treatment was 32.2 days. More than half of the inpatient stays were 21 days or less, and almost a fourth were seven days or less. The average cost per admission was $3,887 (January 1980 dollars), and the average number of admissions per person utilizing inpatient care was 1.57. No data were available on whether the inpatient stays were in specialty facilities or general hospitals.

Ambulatory care was used by 83.7 percent of those receiving mental health treatment, and they had an estimated 22 mental health ambulatory visits per person during the study period. The number of estimated visits is based on claims data from institutional providers only; whether a similar number of visits were made to private practitioners is unknown. The primary providers of ambulatory mental health care were physicians, who accounted for 71 percent of total visits (Aetna's codes did not distinguish between types of physicians); psychologists, who accounted for 20 percent; and psychiatric social workers, who accounted for slightly more than 3 percent.

Pre-post patterns of medical care

Total medical care costs and utilization for individuals receiving mental health treatment were analyzed using the first such treatment event as a reference point. Individuals began treatment during each month of the study period, and there were varying amounts of data available for analysis before and after initiation of treatment. For example, persons beginning treatment in early 1980 would have only a few months of pretreatment data but more than three years of posttreatment data. For those whose initial treatment was in mid-1983, the opposite situation applied.

The primary research question

ues were $108 (31 to 36 months), $128 (25 to 30 months), $124 (19 to 24 months), $126 (13 to 18 months), $147 (seven to 12 months), and $493 (one to six months). Posttreatment initiation values were $239 (one to six months), $183 (seven to 12 months), $167 (13 to 18 months), $158 (19 to 24 months), $144 (25 to 30 months), and $137 (31 to 36 months).

These data illustrate the gradual rise in total health care costs over the 36-month period before the start of mental health care and a sharp climb in such costs in the six-month period immediately prior to treatment. After treatment began, total costs dropped continuously over the following 36 months.

The longitudinal patterns of age and gender subgroups were similar to that of the overall study population. However, important differences between subgroups did exist. One way of examining these differences is to evaluate the extent to which the health care costs of persons receiving mental health treatment converge with the cost levels of individuals of similar age or sex from the random sample of families in which no members received mental health treatment.

For each six-month interval defined above, monthly total health care costs of treated individuals were transformed into a proportion of the average monthly per-person health care costs of the corresponding age or sex cohort from the random sample. The age and sex cohort provides a baseline for the expected level of cost on the average. For each month of the study period, average total health care costs for the mental health patients (defined by age group or gender) were divided by the monthly average for the corresponding age or sex cohort to develop an index or ratio. Thus a value of 1 indicates that the monthly average for any interval was equal to the monthly four-year average of the baseline group. A value less than 1 means the mental health treatment group experienced costs less than the baseline, and a value greater than 1 indicated costs higher than baseline.

All of the three youngest treatment subgroups (under 14, 14 to 19, and 20 to 24) incurred initial costs (in the 31- to 36-month pretreatment period) that were higher than their age cohorts, with values of 1.47, 1.19, and 1.61, respectively. By the end of the follow-up period (31 to 36 months after initiation of treatment), health care costs for all groups remained considerably higher than for their age cohorts (2.49 for those under age 14, 3.17 for ages 14 through 19, and 2.44 for ages 20 through 24). The 14 to 19 age group had the highest costs relative to their nontreatment age cohort at the time of initiation of treatment. Their costs peaked at a level 23 times higher than their general age cohort.

Compared with their younger counterparts, mental health patients in the three older subgroups (25 to 44, 45 to 64, and 65 and older) incurred costs that converged more closely with those of their age cohort by the final posttreatment interval (31 to 36 months). This is illustrated by the values of 2.12 for those between age 25 and 44, 1.73 for those between age 45 and 64, and 1.37 for those age 65 and older.

Cost ratios for males and females were also analyzed. Females in the treatment group initially (31 to 36 months prior to treatment) had total health care costs per month that were significantly higher than costs for females in the random sample (a proportional value of 1.77). Males receiving mental health treatment, however, had costs comparable to males from the random sample baseline at this point (1.01). By the final posttreatment period, males were closer to the levels of the random sample (1.66) than were females (1.99), although the costs for treated females were closer to their actual pretreatment costs.

Conclusions

The results of this study provide confirmation of the findings of previous studies as well as provide new findings, previously unreported, concerning the question of the potential for mental health treatment to reduce other health care costs.

In this study, the total health care utilization and costs of Aetna FEHBP-enrolled families receiving mental health treatment were higher than those of a demographically similar comparison group of enrolled families not receiving mental health treatment.

The longitudinal pattern of total health care costs illustrates that a marked increase in such costs among individuals with mental health problems can be expected over the 36-month period prior to initiation of treatment. A decrease in total health care costs can be expected following the start of mental health treatment—even when the costs of this treatment are included. This is in contrast to Borus and associates' finding (13) that offset savings in general ambulatory medical care were overshadowed by charges for the specialty mental health care itself.

Our analysis of specific age subgroups indicates that subpopulations are differentially contributing most to the overall drop in total health care utilization. The best convergence with the baseline level of their general age group cohorts occurred for patients who were age 65 and older, followed by those in the 45 to 64 age group. The two youngest groups, ages 14 to 19 and under age 14, had the least convergence with their general age group cohorts. It is possible that these differential cost patterns are due in part to age-related variations in specific diagnoses or in severity of mental illness. This issue could not be addressed with the data available for this study but merits further investigation.

It is not possible to estimate exactly how much of the decline in health care utilization after initiation of treatment is due to treatment per se versus other factors such as self-selection and motivation, regression toward the mean, and so forth. The relatively long periods before and after initiation of treatment used in our analyzes, however, provide a valuable perspective for evaluating this issue.

Statement by Congressman John Myers

Subcommittee on Compensation and Employee Benefits
Federal Employees Health Benefit Plan (FEHBP)
May 11, 1988

Mr. Chairman. I commend you on conducting these timely hearings on the Federal Employees Health Benefit Plan (FEHBP). I am sure that most everyone in this room has already taken the time to read the OPM report conducted by Towers and Perrin. The report has proven to an excellent investigation into the FEHBP, and I look forward to receiving testimony and working toward crafting a health care program that meets the needs of all federal employees.

Franklin D. Roosevelt once said, "We have nothing to fear except for fear itself." When federal employees are forced to select a health care provider, it seems that fear and confusion prevail. Because there are so many different plans available, most are forced to rely upon fellow co-workers for information about health care. Obviously, this is no way to choose a health care provider. With over 50 different plans offered in the Washington, D.C. area it's no wonder federal employees are forced to deal with health insurance in such a manner.

Most health care professionals will agree that health care has changed more in the last five years than in the previous 25 and more changes are expected in future. Federal employees and retirees need a health care program that will meet the needs of this vast group and yet be flexible enough to meet future changes in the health care industry.

(over)

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HealthCare COMPARE

JOINT STATEMENT OF
ROBERT J. BECKER, M.D., CHAIRMAN
AND
JAMES C. SMITH, PRESIDENT
HEALTHCARE COMPARE CORPORATION

BEFORE THE
SUBCOMMITTEE ON COMPENSATION
AND EMPLOYEE BENEFITS
HOUSE POST OFFICE AND CIVIL SERVICE COMMITTEE
MAY 11, 1988

HC 1 (2-88)

JOINT STATEMENT OF
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BEFORE THE
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HOUSE POST OFFICE AND CIVIL SERVICE COMMITTEE
MAY 11, 1988

Mr. Chairman and Members of the Subcommittee:

HealthCare COMPARE appreciates the opportunity to submit this written statement for the record of these hearings. In your letter of invitation, you indicated that the purpose of this Federal Employees Health Benefits ("FEHB") Program oversight hearing was to entertain comments about the recent increase in FEHB Program premiums, the potential for expansion of health benefits, and possible reforms to the FEHB Program. In consideration of the magnitude of these issues, we will confine our remarks to our area of expertise, and to an issue which we believe affects critically each of these concerns regarding the FEHB Program -- namely utilization management as a prescription for unnecessary and wasteful FEHB Program costs.

Background

HealthCare COMPARE is a public company which performs utilization management nationwide for insurance carriers and administrators, corporate employee benefit plans, HMO/independent practice associations, Taft-Hartley union trusts and government health benefit plans. We are, by most measures, the industry leader as the largest independent utilization management company

in America. As a consultant to payors of health benefits, COMPARE provides professional, physician-directed medical necessity recommendations and certifications. The most important programs we provide include hospital preadmission and continued stay review, a managed second surgical opinion and waiver program, medical case management and discharge planning, mental health services review, chiropractic review, dental review and disability review. Descriptions of these programs are appended to this statement as Exhibit A.

COMPARE currently subcontracts to provide six FEHB employee organization sponsored fee-for-service plans with a range of utilization management services designed to reduce unnecessary and wasteful medical care services which are not appropriate to patient conditions, diagnoses, illnesses, or injuries in accordance with the plan's medical necessity criteria.

Utilization Management's Role in the FEHB Program

Many health policy commentators have maintained that, as a society, we must commit ourselves to finding effective ways of delivering only medical care which is truly necessary. That this is a lofty and costly goal is borne out by the ever increasing cost of health care, which today stands at roughly 11 percent of the gross national product. Because of this recognition of increasing costs, the health policy community generally agrees that, if we are to achieve or even approach that goal, we cannot afford to deliver care which is medically unnecessary at sites

which are too costly. The cloud looming over health policy discussions in both the private sector and federal sector is the growing health care bill and, for the FEHB Program, it is reaching overwhelming proportions.

The issue of how much we pay for medical care can be considered as a relatively simple equation:

Cost of Health Care	=	Number of Units	x	Price Per Unit

In other words, the cost of health care equals the number of hospital days, the number of physician visits, ordered tests and procedures, etc. ("units") multiplied by the price per hospital day, the price per physician visits and consults, and the price per laboratory test and x-ray, etc. Utilization management goes to the crux of this equation -- control health plan expenditures and program costs by controlling the number and nature of "units" delivered based on medical necessity determinations.

The Federal Government, as an employer offering health insurance for 4 million active and annuitant enrollees and their dependents through the myriad of plans in the FEHB Program at a total annual cost of over $11 billion, has at its disposal the capability to protect the financial integrity of the FEHB Program by requiring all plans to implement uniform, mandatory medical necessity utilization management programs. Only in this way can the FEHB Program properly manage its risk, fuse benefits provided to the most efficient use of premium dollars, stop the diversion of scarce benefit dollars to wasteful and/or overpriced services and supplies, and ensure delivery of medical care in settings

appropriate to patient conditions, diagnoses, illnesses or injuries. Without a program-wide emphasis, individual plans, which act responsibly by requiring utilization review, are perceived to be placing themselves at a competitive Open Season disadvantage due to enrollee misconceptions about participation requirements associated with such programs. Thus, those plans acting responsibly by implementing such effective cost containment efforts are needlessly burdened by additional Open Season, and continual year-around, educational expenditures and efforts to provide the enrollee with appropriate conceptions and perceptions of:

1. The overall role of utilization review (e.g., the avoided harmful side effects, health dangers, and premium costs of unnecessary procedures and hospital stays);

2. The impact of review on treatment decisions (e.g., access to the most current and state-of-the-art treatment modalities); and

3. The ease or simplicity by which the enrollees can participate in the review process (e.g., easy toll-free telephone calls to initiate review).

Ironically, this extra burden falls only on responsible plans. Through their implementation of such utilization review, these plans act to protect both FEHB Program monies and enrollee pocketbooks by helping to keep plan expenditures, and thus rates, limited to paying for only medically necessary care. The inconsistent system of the use of utilization management currently in place leaves substantial pockets of vulnerability for the Federal Government wherein FEHB plans, which have not instituted medical necessity utilization review, pay for wasteful supplies, inefficient treatment modalities and services at inappropriate and costly sites. Under the present system, FEHB plans, the Government, and ultimately the enrollees are exposed to the increased cost of paying for wasteful and inappropriate care both related and unrelated to specific patient conditions, diagnoses, illnesses or injuries.

We recognize that to implement comprehensive utilization management might generate opposition against the imposition of mandatory plan benefit designs. However, program-wide application of mandatory utilization management should not be considered the same as mandatory plan benefits. Utilization of medically unnecessary services is, in and of itself, a program-wide problem costly to all parties. Utilization management, however, is an effective method for the Federal Government as an employer, like other employers, to place a lid on the societal problem of wasteful utilization of health care resources. The Federal Government and the American taxpayer can ill afford to pay for medically unnecessary or inappropriate care merely to retain the status quo

appease parochial notions about the FEHB Program competitive model. As the recent Towers, Perrin, Forster and Crosby ("TPF&C") study commissioned by the Office of Personnel Management ("OPM") indicates, the present model places far too much emphasis on competition at the "seeking of enrollees" level with the attendant effect of risk segmentation that causes the Federal Government, and enrollees as a whole, to spend more than is necessary for health benefits protection.

The "Open Season" door swings both ways -- while effective utilization review lowers plan costs, it plays only an incremental role in the aggregate benefit and rate package. The savings generated, while substantial, are at the margin of the total cost of any particular plan, which is influenced far more by the plan's overall benefit content and design. While the impact of utilization review cannot by itself guarantee appealing rates -- too many other factors influence price and enrollee Open Season decisions -- utilization review can ensure that the individual plan is getting the most per dollar of benefit cost, and, if and when that concept is engrafted on the FEHB Program as a whole, it can and will ensure the same results for the Program as a whole, and thus benefit both its sponsor and its participants.

Support for utilization management as a cost containment technique is broad and solid. Numerous studies in both the Federal sector and private sector have recognized the prudence and value of medical necessity utilization management programs. The investigative arm of Congress, the General Accounting Office

("GAO"), has been a strong advocate of the advantages and cost effectiveness of medical necessity utilization management.

At the behest of Congress, the GAO studied the process and in its report, entitled OPM Should Promote Medical Necessity Programs for Federal Employees' Health Insurance (GAO/HRD-80-79 July 29, 1980), suggested that OPM:

> [N]eeds to keep abreast of medical necessity program developments both in and outside the Federal Government (and) increase its involvement in making better use of medical necessity programs.

The overall recommendations of the General Accounting Office were:

> To make sure that medical necessity programs receive appropriate attention and consideration, the Director, OPM, should:
>
> --Systematically monitor developments in these programs, in both the private and public sectors.
>
> --Evaluate these programs to determine how Federal Employees Health Benefits [P]rogram plans might use them to foster better health care and lower health insurance costs.
>
> --Require the Federal Employees Health Benefits [P]rogram plans to use aspects of these programs that are proven beneficial.

Moreover, the Comptroller General's study entitled Constraining National Health Care Expenditures -- Achieving Quality Care at an Affordable Cost, (GAO/HRD-85-105 September 30, 1985) confirmed that:

> [A major factor] contributing to increased utilization of health care services . . . [is the] unnecessary and/or inappropriate utilization of services (p. 149)

* * *

> Numerous studies have demonstrated that a substantial but unknown amount of health care provided is either medically unnecessary or inappropriate (p. 151)
>
> * * *
>
> [E]ven without total agreement concerning the magnitude of the problem of unnecessary and inappropriate services, there is sufficient agreement to support the view that the potential savings are substantial (p. 152)

Still, in spite of the weight of authoritative evidence supporting utilization management as an effective and necessary cost containment tool, OPM, to date, has not endorsed the need to coordinate policy and fully implement mandatory utilization review as a requirement across the FEHB Program. As the Comptroller General noted:

> OPM believes that plans should not be required to conform to prescribed OPM regulations but should instead have the flexibility to try their own cost-saving strategies. OPM believes that adequate incentives for this to occur exist in FEHBP because inefficient plans will be eliminated from the program as a result of competition from other plans. (p. 211)

The FEHB Program's actual utilization experience, and the recent TPF&C study, have pointed out the ineffectiveness of this hands-off posture toward comprehensive mandatory utilization management. In fact, among the most feasible, and most easily implemented, recommendations made by TPF&C was:

> All plans should be required to implement preadmission review, individual case management for large claims and other effective cost containment measures [OPM Contract 87-9027, p. 152]

A Final Note
All Review is NOT Equal

The issues raised by the Subcommittee in these oversight hearings -- the recent increase in FEHB Program premiums, the potential for expansion of certain health benefits and possible reforms to the FEHB Program -- all must be considered in the context of the level of program-wide utilization of health care resources, its costs and how to manage it. Getting control of health care costs starts with the recognition that only physicians treat, test, hospitalize patients, and perform surgery. Therefore, any move to effectively control health care costs through utilization management must involve those attending physicians actively in that process, beginning with the hospital preadmission and continued-stay review processes. Truly effective cost management results from altering physician practice patterns and habits. We are pleased to report that those habits are indeed changing, but there is still a long way to go.

There are real distinctions between programs which are generically called "utilization review." We at HealthCare COMPARE maintain that there is a marked superiority in a program design which includes, at a minimum, second stage physician-to-physician dialogue in a large percentage of all cases under review because it is that objective physician involvement which sets utilization review programs apart in terms of savings achieved and sensitivity to enrollee and patient concerns. It is important, however, that the reviewing physician not have financial, referral, social, or constituency relationships with

the attending physician. Conflicts of interest must be avoided by maintaining the objective physician review oversight ability. Real cost management, which does not leave a trail of unhappy enrollees and non-compliant attending physicians, demands objective physician direction and involvement, rather than impersonal and insensitive "cookbook medicine" which can emanate from simple algorithm approaches.

Identifying patients who can be treated safely at home, or in some other appropriate place, rather than in an acute care hospital requires knowledge of illnesses and of all available technologies and methods for treating illness. Thus, a full understanding of the patients' actual diagnoses and conditions, the anticipated treatment plan, and any planned or contemplated surgical or other procedures are critical to effective utilization review. Fragmentation, or a lack of coordination, of such knowledge cannot be tolerated in an effective review program.

In this regard, the most sensitive, and cost effective time to begin medical case management of potential large cost cases is as soon as possible. To do this, medical case management identification must be initiated by incorporation into a preadmission, continued-stay module of a comprehensive utilization review program, rather than by less sophisticated and more costly methods such as claim dollar amount or hospital length of stay thresholds employed by some utilization review initiatives. Highly skilled professional judgment is needed to determine which cases will require actual, hands-on case management, and to

ascertain whether alternative delivery modes of necessary care are medically safe, demographically available, truly cost effective and ultimately more desirable for the well being of patient and his/her family.

The paramount goal of effective utilization management must be to orchestrate the coordination of the patient, the most effective technologies and information, and the attending physician in the most cost-effective environment. In achieving that goal, the use of independent, physician-directed medical assessments in evaluating medical necessity questions greatly strengthens the validity and effectiveness of utilization management. It contributes significantly to ensure quality by separating medical necessity decisions from the payers and deliverers of the health care system.

We thank you for your interest in our comments and hope that they will be helpful in your performance of your oversight role regarding the FEHB Program. We stand ready and willing to assist the Subcommittee in any way you desire as it considers the issues addressed in this statement.

EXHIBIT A

HOSPITAL REVIEW

The COMPARE Hospital Review Program works like this:

Preadmission Certification

Before admission to the hospital, the enrollee, patient, family, friend, or physician makes a toll-free call to a HealthCare COMPARE coordinator to provide basic demographic information:

...patient name, birth date, phone, etc.
...reason for hospitalization
...proposed treatment or surgery
...number of hospital days planned

HealthCare COMPARE will review these data and notify the patient, the attending physician, the hospital and the claims administrator that the admission (and number of inpatient days) can be recommended for certification of medical necessity under the terms of the health benefit plan.

If certification cannot be recommended, the case is referred to a HealthCare COMPARE physician consultant who immediately calls the attending physician. With rare exception, questions are quickly resolved through this physician-to-physician review which takes place in 40 percent of all cases.

Emergency Admissions

If a patient is admitted to a hospital on an emergency basis, HealthCare COMPARE prepares a review if notified within two business days. Again, the case will be reviewed by a HealthCare COMPARE coordinator (or a physician consultant) and certification recommendations and length of stay assignments will be completed.

Continued Stay Review

On the day after a scheduled admission, HealthCare COMPARE calls the hospital to verify that admission. On the day before a stay is scheduled to end, HealthCare COMPARE calls the attending physician to verify discharge or, to initiate review if additional days are requested.

SURGICAL OPINION

The COMPARE Managed Second Surgical Opinion and Waiver Program works like this:

1. When the attending physician recommends surgery, the enrollee/patient checks his/her brochure to see if the procedure requires a second opinion.

2. If a second opinion is required, the attending physician or an assistant calls HealthCare COMPARE with the information about the case.

3. In eight to ten percent of all cases, the procedure will meet the strict guidelines that allow the second surgical opinion requirement to be waived by the HealthCare COMPARE coordinator.

4. All remaining cases are referred to HealthCare COMPARE review physicians. They can waive the second surgical opinion in an additional thirty to forty percent of the cases. This screen to waive second opinions not only saves consultation costs, it helps avoid delay when surgery is clearly needed.

5. When a second opinion is necessary, HealthCare COMPARE sends the names and telephone numbers of local board-certified specialists who can provide it. The patient selects the specialists and schedules an appointment.

6. Second opinion physicians perform independent examinations including necessary diagnostic procedures. Then, they provide an opinion for the patient to consider. Finally, they call HealthCare COMPARE with their findings.

7. When there's agreement between the surgical recommendation and the second opinion, HealthCare COMPARE notifies the patient and the claims administrator that no further opinions are needed. Because of obvious legal ramifications regarding the doctor/patient relationship and treatment decisions, decisions as to actual hospitalization or the rendering of particular medical services are made only by the patient and the attending physician which decisions are separate and distinct from a plan's payment decision.

8. If the initial recommendation and the second opinion disagree, HealthCare COMPARE notifies the patient and the claims administrator that a third opinion should be obtained. The same objective procedure is used for obtaining a third opinion to clarify the recommended course of treatment.

CASE MANAGEMENT

COMPARE Medical Case Management can extend cost effective insurance benefits by researching options to the long hospital stay. The program works like this:

1. A daily database search by HealthCare COMPARE computers identifies candidates for long hospital stays within two days of a patient's admission review.

2. HealthCare COMPARE gets authorization from the plan or its claims administrator to review the case.

3. A consulting physician from HealthCare COMPARE reviews all of the information on a case and discusses it with the attending physician.

4. Frequently, national HealthCare COMPARE physician specialists will also review the case and give an opinion regarding alternative care.

5. The attending physician confers with the HealthCare COMPARE consulting physician and the national specialists. Then, HealthCare COMPARE develops the appropriate options such as negotiated cost effective vendor discounts and obtains the claims administrator's approval for "payment by exception" if necessary.

6. If a patient and attending physician choose alternative care, instead of extended hospitalization, HealthCare COMPARE notifies the plan and the claims administrator about the option selected and that home care, family training, etc. are to begin.

7. HealthCare COMPARE continues its review until:

...service is no longer required.
...benefits are exhausted.
...life-long service is needed.

Before case management review is discontinued, the patient, attending physician and claims administrator are notified by HealthCare COMPARE.

MENTAL HEALTH SERVICES REVIEW

COMPARE's Mental Health Services Review Program works like this:

Certification

Prior to admission, the attending mental health practitioner calls a HealthCare COMPARE coordinator to provide information about the case. HealthCare COMPARE reviews this data and notifies the patient, the attending practitioner and the claims administrator that the admission can be certified as medically necessary under the terms of the benefit plan.

Emergency Admissions

If admission for psychiatric care is on an emergency basis, HealthCare COMPARE can prepare a review if notified within two business days.

Mental Health Extension Review

INPATIENT CARE: HealthCare COMPARE initiates all extended stay reviews. The day before a stay is scheduled to end, HealthCare COMPARE calls the attending practitioner to verify discharge.

ALCOHOL OR SUBSTANCE ABUSE CARE: HealthCare COMPARE calls the attending practitioner at the midpoint of the treatment plan to confirm the patient's progress. The day after the projected end date of the previously certified days, HealthCare COMPARE calls to confirm discharge.

Outpatient Therapy

If an attending practitioner proposes more than seven sessions, review is required. After the seventh session, the attending practitioner calls HealthCare COMPARE to initiate the full review process and to provide the information needed to certify outpatient care as medically necessary.

Outpatient Extension Review

HealthCare COMPARE initiates all extension reviews for outpatient care. The day before a treatment program is scheduled to end, COMPARE calls the attending practitioner to verify completion of the program.

DISABILITY MANAGEMENT

The COMPARE disability management program offers a second opinion on a patient's condition and the amount of time an employee needs to stay out of work.

Using the case data gathered by HealthCare COMPARE computers and an examination by local, board-certified specialists the attending physician's findings can be confirmed or alternative care identified. This can save the unnecessary cost of many extra working days lost.

COMPARE's physician network provides this service anywhere in the country.